

THE MEDICAL JOURNAL OF AUSTRALIA

Vol. I.—31ST YEAR.

SYDNEY, SATURDAY, MARCH 11, 1944.

No. 11.

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A SIMPLE MEDIUM FOR THE DETECTION OF *CORYNEBACTERIUM DIPHTHERIAE*¹

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The clinical diagnosis of diphtheria is not always made immediately and accurately, because the appearance of the throat is not always characteristic at the first examination of the patient. It is for this reason that the detection of *Corynebacterium diphtheriae* in throat swabs needs to be carried out accurately and rapidly if it is to achieve useful cooperation between physician and bacteriologist.

Differential media, which generally contain a salt of tellurium, have been in use for many years. Several independent investigators have established the greater accuracy of the tellurite medium in the detection of *Corynebacterium diphtheriae* in throat swabs.⁽¹⁾⁽²⁾⁽³⁾ Nevertheless, Löffler's medium is still the standard one in many laboratories. Perhaps the tellurite medium would be more widely used if it was more generally realized that this technique is simpler than others, as well as being more accurate, once experience has been gained, and that it saves time, because the majority of swabs containing none of the organisms can be determined at a glance.

In recent years a number of different tellurite media have been described, many of them excellent in experienced hands.⁽⁴⁾⁽⁵⁾⁽⁶⁾⁽⁷⁾⁽⁸⁾ The aim of the present study has been to devise a medium with the following characteristics: (i) Preparation should be simple. (ii) Constituents of the medium should be stable. (iii) Growth of micro-organisms other than *Corynebacterium diphtheriae* and diphtheroids should be suppressed. (iv) The colonies of *Corynebacterium diphtheriae* should be readily recognizable, and it should be possible to classify them at once into *gravis*, *mitis* and *intermedius* types. (v) Confirmation by microscopic examination should be possible if doubt exists about any particular colony.

¹Work done with a grant from the National Health and Medical Research Council.

It is the purpose of this paper to describe a medium with these characteristics, with the exception that it is not possible by its use to classify *Corynebacterium diphtheriae* accurately into three types. It differs little from the medium described by Hoyle⁽⁶⁾ and later modified by Young.⁽⁵⁾ These media have the same weakness—namely, that type differentiation is not always easy. Zimmernann and Johnstone⁽⁸⁾ have recently described a medium designed to overcome this difficulty, but it is not so simple to prepare.

Technique.

Materials.

The tellurite medium is made by mixing together potassium tellurite, glycerolated sheep's blood and nutrient agar.

The nutrient agar is prepared in accordance with the method of H. D. Wright and is in common use as stock in many laboratories, and will not be described in detail. Briefly, to meat extract are added 0.5% sodium chloride, 1.0% peptone (Parke, Davis and Company) and 2.5% powdered agar, the pH is adjusted to 7.6, and after filtration by suction the agar is distributed in amounts of 100 cubic centimetres and autoclaved.

Glycerolated sheep's blood is prepared in small amounts as follows: 5.0 cubic centimetres of sterile defibrinated sheep's blood and 2.5 cubic centimetres of sterile glycerol are measured into a sterile test tube, sterile pipettes being used. The mixture is kept in the ice box for three weeks, before use, being shaken at intervals to ensure haemolysis. It keeps indefinitely in the cold. Human blood is unsuitable; horse blood can be used, but it is not so good as sheep's blood. Rabbit's blood is satisfactory, but limitation of supply is a handicap.

The tellurite solution is prepared as follows: 2.0 grammes of potassium tellurite (British Drug Houses) are dissolved in 100 cubic centimetres of distilled water and autoclaved for ten minutes at ten pounds' pressure. Complete solution does not occur. The flask should be stored in a dark cupboard at room temperature and well shaken before use. Solutions protected from evaporation have been tested at intervals during fifteen weeks and found to be satisfactory. It has been found that samples

of potassium tellurite vary considerably, and each batch should be tested before being put into routine use. Intensely deliquescent specimens, such as were used in the early part of this work, call for a 2% solution to produce the desired result. Quite recently a dry, whitish powder has been tested, which gave comparable results in 1% solution.

The plates are prepared by melting 100 cubic centimetres of the agar base, cooling to 45° C. and adding 4.0 cubic centimetres of tellurite solution and 20 cubic centimetres of glycerolated blood; this is mixed well and the plates are poured. This amount is sufficient for nine plates of nine centimetres' diameter—that is, about 14 cubic centimetres per plate. A smaller amount is prejudicial to maximal growth.

Löffler's medium is prepared according to the method recommended by Goldsworthy and Wilson,⁽⁶⁾ by adding one part of sterile glucose broth to four parts of Seitz-filtered horse serum. The mixture is tubed and sloped with sterile precautions, and then inspissated for two hours at 85° C.

For the toluidine blue stain, solution A is made by dissolving 0.2 gramme of toluidine blue in 2.0 cubic centimetres of absolute alcohol and adding 98 cubic centimetres of distilled water. Solution B is made by adding one cubic centimetre of glacial acetic acid to 100 cubic centimetres of distilled water.

Fermentation media are prepared in the usual way. To peptone water are added, from sterile solutions, Andrade indicator, 1% of the desired sugar, and 10% of sterile horse serum. The glycogen medium, however, is prepared in amounts of one cubic centimetre in small tubes, three and a half inches by half an inch in size, and no horse serum is added. It has been found that this gives satisfactory results if large inocula are used.

Rabbit's blood agar plates are prepared in the usual way.

Source of Material.

Swabs were obtained from patients provisionally thought to be suffering from diphtheria, and from diphtheria patients in the acute or convalescent stage. The swabs were placed in dry, sterile test tubes, and periods up to four hours elapsed before they were inoculated onto the media.

Laboratory Procedure.

The swab was first rubbed over the surface of a tube of Löffler medium, and then over one-third of a plate of the tellurite medium. Both cultures were examined after eighteen to twenty hours' incubation at 37° C. A smear from the emulsified growth on the Löffler slope was dried and fixed and stained by being flooded with solution A for half a minute to one minute; it was then washed clear with solution B for half a minute to two minutes. It was then dried and searched for half a minute to three minutes for typical bacilli showing metachromatic granules. The tellurite plates were examined with the naked eye and the colony microscope; a smear was made from a typical colony and stained as described above. Pure cultures were obtained by plating out a single colony on rabbit's blood agar, and fermentation media of glucose, saccharose and glycogen were inoculated. If the Löffler plate gave a positive result and the tellurite plate did not, the Löffler culture was subcultured onto tellurite medium, and the plates were examined for the presence of *Corynebacterium diphtheriae*.

Examination of Löffler Cultures.—Care was taken to emulsify all the growth on the slopes inoculated from the throat swabs, so that representative samples were examined. From time to time, pure cultures of the three types of *Corynebacterium diphtheriae* were grown for eighteen hours, stained by the modified toluidine blue technique and examined to see that granule formation was satisfactory.

Examination of Tellurite Plates.—The tellurite medium is very selective, and little growth other than that of *Corynebacterium diphtheriae* and diphtheroids appears on it. Colonies of *Corynebacterium diphtheriae* after eighteen hours' incubation are two to four millimetres in diameter

and dark grey in colour, and have a metallic sheen. The colony of the *gravis* type is flat, has a matt surface and a more or less irregular edge, and displays a "crust" which cracks when touched with a wire. The colony of the *mitis* type has the appearance of a low dome with a smooth surface and an entire edge, and is of a butyrous consistency. The *intermedius* colony is a low dome smaller than the other two, and has a coarsely matt surface. The colony of *Corynebacterium Hofmanni* is conical and light grey in colour, and tends to have a transparent edge, giving a "bird's-eye" appearance. Smears from these colony types, when stained by the toluidine blue-acetic acid method described above, have the following appearances. The *gravis* organism has the appearance of a stout rod with blue-staining cytoplasm, and a proportion of the organisms have granules. The *mitis* type presents the classical appearance of a slender rod, longer and paler than the *gravis* organism, and the majority of the rods have well-developed metachromatic granules. The *intermedius* type shows strong "barring" with pale blue areas between the dark bars. The morphological characteristics of *Corynebacterium Hofmanni* after eighteen hours' incubation are characteristic, the bacilli being short, uniform in size with an unstained central bar and without granules, though in some strains granules develop after forty-eight hours' incubation.

Identification of *Corynebacterium Diphtheriae*.—For routine work, the double identification of *Corynebacterium diphtheriae* by means of colonial appearance and microscopic morphological characteristics seems to be accurate, and fermentation tests may be omitted. Of course, if there is doubt these must be set up. For type differentiation, it is safer to rely on a subculture on rabbit blood agar, and since atypical colonies of the *gravis* type are common, glycogen fermentation tests are helpful.

A Simplification of the Method.

The main investigation (interrupted by the war) was carried out with the medium described earlier. Recently, further investigation and the results of other workers have suggested the following simplification, which is recommended.

1. Hoyle⁽⁴⁾ has shown that "Lab Lemco" can replace meat infusion. This has been confirmed. A satisfactory base can be prepared with 0.5% "Lab Lemco", to which are added 0.5% sodium chloride, 1% peptone (Parke, Davis and Company) and 2.5% powdered agar; the pH is adjusted to 7.6 and the mixture is autoclaved. Filtration is not necessary.

2. As Zinnemann and Johnstone⁽⁵⁾ have suggested, it is possible to combine the tellurite and glycerolated sheep's blood into one mixture, which is made in the following way. Into a sterile flask 14 cubic centimetres of sterile defibrinated sheep's blood, six cubic centimetres of sterile glycerol and four cubic centimetres of 1% tellurite solution are measured. (This sample of powdered tellurite was the dry, whitish powder to which reference was made earlier.) The mixture is placed in the incubator for one or two hours and then in the refrigerator. After twenty-four hours haemolysis is complete, and the mixture may then be used. It keeps well in the ice box. The medium is prepared by melting 100 cubic centimetres of the unfiltered agar base, cooling to 45° C. and adding the contents of one flask of the glycerolated blood and tellurite mixture, and mixing well; the plates are then poured.

Results.

Seven hundred and fifty-two swabs were examined by the Löffler slant and the tellurite plate technique, and the results are shown in the following summary:

Swabs "negative" by both methods	406
Swabs "positive" by both methods	212
Swabs "positive" by tellurite plate only	119
Swabs "positive" by Löffler slope only	15

Corynebacterium diphtheriae was isolated from all "positive" cultures and identified by fermentation. *Corynebacterium diphtheriae* could not, however, be isolated from nine cultures "positive" by the Löffler slope method only. It is probable that in some at least of these a

mistake was made in the interpretation of the original smear from the Löffler slope.

In the early and acute stages of the disease there was a general agreement between results obtained by the two methods, as might have been expected. During convalescence the detection of small numbers of organisms made apparent the greater efficiency of the tellurite technique.

In a few instances colonies of *Corynebacterium diphtheriae* could not be detected on the tellurite medium after twenty-four hours' incubation, but were visible after forty-eight hours' incubation, while the parallel Löffler slopes failed to show any bacilli.

Discussion.

Several good tellurite media are now available for the detection of *Corynebacterium diphtheriae*. The medium described in this paper is prepared as easily as blood agar, and the interpretation of the cultures after direct inoculation of the swab is not difficult. In case of doubt, a smear can be made from a particular colony and stained in the manner described, and a reasonably certain diagnosis can be made from the microscopic appearance of the organisms, since the diphtheroids found in the throat do not show metachromatic granules at this stage of their growth. If doubt still exists, fermentation tests may be carried out at once, since an isolated colony is almost always available for subculture.

Löffler's medium has rendered yeoman service in the control of diphtheria; yet it has a number of disadvantages. The medium must be carefully prepared with a minimum of heating if the microscopic morphological characteristics of *Corynebacterium diphtheriae*, particularly the *gravis* type, are to be evident. Again, if there are only a few organisms on the throat swab, their presence may be hard to establish, even after inoculation of the Löffler slant, on account of the rich growth of other organisms. This is the main reason why the tellurite technique is more accurate, since even one bacillus will probably grow into a recognizable colony because of the differential selective action of the tellurite. Further, if one is in doubt about the identity of an organism seen in a smear from a Löffler slant, the only course is to plate out the growth, in order to obtain a pure culture for identification, and thus a day is lost. Because of this loss of time, when an answer is required quickly, the bacteriologist is often forced to guess, and this is still another reason why the tellurite technique is more accurate. The tellurite plate also presents information as to the number of organisms present on a swab. The growth from an untreated patient is usually confluent; but in swabs from the convalescent patient or the carrier, the colonies of *Corynebacterium diphtheriae* are usually much fewer in number. If serial swabs are being examined, records may be kept, while for first swabs from which only a few colonies grow, the colony count may prove a more useful report to the clinician than the conventional phrase "*Corynebacterium diphtheriae* present", and may make possible a more critical review of the diagnosis.

It has not been found possible to prepare a simple tellurite medium on which accurate type differentiation takes place in twenty-four hours. There is no doubt that this is a desirable characteristic of a diagnostic medium; but there is a doubt whether simplicity of preparation should be sacrificed for this purpose. Perhaps the best medium for colony differentiation is the rabbit blood agar described by Goldsworthy and Wilson,¹⁰ because, while it gives reasonably good differentiation between *gravis* and *mitis*, the *intermedius* colony cannot be mistaken for either. There will remain certain strains which are difficult to classify. Some have a smooth *mitis*-like colony, but ferment glycogen; other strains have a rough *gravis*-like colony, but do not ferment glycogen. Clearly any classification based on biological characters of these atypical strains is unsatisfactory. While this paper is not concerned with type distribution, it may be of interest to record that no strain of the *intermedius* type has been encountered during the progress of the work in the metropolis of Sydney.

Summary.

1. A simple tellurite medium is described, which is highly selective for *Corynebacterium diphtheriae*, and which, in addition, permits a confirmatory microscopic examination to be carried out.

2. Seven hundred and fifty-two swabs were cultivated on the tellurite medium and on Löffler's medium; 212 swabs gave positive results on both media, 119 gave positive results on the tellurite medium only, and 15 gave positive results on Löffler's medium only.

3. It is believed that the medium described is suitable for routine diagnostic work, and that it gives more accurate results than Löffler's medium.

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Reports of Cases.

A CASE OF AORTIC THROMBOSIS.

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AORTIC THROMBOSIS is a rare condition simulating acute abdominal disease. Very few cases have been reported. Osler and McCrae,¹ together with Mazoux,² describe the condition. It is difficult to distinguish between embolism and thrombus formation, as a thrombus may produce at times symptoms as sudden and as acute as those produced by an embolus. On the other hand, an embolus may in rare instances become lodged without the production of serious symptoms. It is difficult to imagine how a thrombus or an embolus could possibly form in such a large artery as the aorta, in which a strong current of blood is constantly surging.

Embolism usually occurs in patients with mitral stenosis, or an embolus may be furnished by a thrombosed aneurysm of the thoracic aorta. Aortic thrombosis, on the other hand, is usually due to diseases of the vessel wall, such as atheroma.

The symptoms vary. They may be sudden or gradual in their onset. In the more rare gradual type, intermittent claudication of gradually increasing severity is the first symptom. Later, severe pain radiating to the limbs is noticed. Sensations of numbness and formication may be felt in the feet. Finally, paraplegia and gangrene of the lower extremities follow. The kind of paraplegia is sometimes of the upper and sometimes of the lower motor neurone type, and is usually incomplete. The reflexes are absent in some cases, while in others associated with paralysis of the upper motor neurone type, they are presumably increased. Gangrene is preceded first by coldness and pallor of the extremities, and later by cyanosis and ulceration. Oedema is not pronounced as a rule and may be absent.

In the majority of cases, however, the onset is sudden. Intense, constant pain referred to the lower limbs, together with prostration, are the most prominent symptoms. The pain may be so severe as to strike the patient to the ground. Rare cases have been reported in which pain was intermittent or even absent. The lower extremities exhibit pallor, followed by lividity of the skin, with impairment of sensation, paresis, and finally muscular paralysis and gangrene. Pulsation of the vessels is absent in both limbs. The lower part of the abdomen may be tender to palpation, and tenderness may also be present over the lower end of the aorta. There may be no rigidity of the abdominal muscles in the early acute stage, but later, as the peritoneal irritation involves the parietal portion of the peritoneum, rigidity develops. A little free fluid may be present in the abdomen. Psychic disturbances and a gradual rise in temperature after the first twenty-four hours may also occur.

Clinical Record.

Mrs. X, aged fifty-two years, was sent by Dr. E. A. Murphy, of Port Macquarie, to the Royal Prince Alfred Hospital for embolotomy on July 2, 1942, with the diagnosis of embolism of the aorta. The patient, who was suffering from auricular fibrillation, had been admitted to a country hospital, where she was making satisfactory progress under treatment with digitalis. No quinine had been given. On the morning of July 1, the day on which the catastrophe occurred, her pulse rate was 74 beats per minute; there were no more than two ectopic beats per minute, and all signs of congestive failure had disappeared. Two hours after going to bed that night the patient suddenly screamed, became restless and excited, and complained of intense pain in both lower limbs, associated with loss of all movement in them; she begged the nurse "to move her legs or rub them or do something". She was seen by Dr. E. A. Murphy about ten minutes after the onset when the pain appeared to be referred to the limbs as a whole rather than to the position of the main arteries. At the onset the pulse was slow (the rate was 52 beats per minute) and small in amplitude, and coupled beats were present; but within ten minutes the rate increased to 90 per minute, while the amplitude became large and the rhythm regular. From the groins upwards the whole body was flushed and sweating; below that level the skin was pale, dry and cold, and no pulsation was felt in the femoral arteries. The abdomen was slightly distended and moderately rigid in all areas, but not tender. Fine crepitations were audible at the bases of both lungs. From the onset all deep and superficial reflexes below the umbilicus were abolished. The next day, under the influence of morphine, the patient was more comfortable. Her maximum blood pressure was 125 millimetres of mercury and her minimum pressure 70; her pulse rate was 94 beats per minute, and her general condition appeared to have improved.

On her admission to the Royal Prince Alfred Hospital, the patient complained of abdominal pain, breathlessness and paralysis of both legs. The skin was pale and sweating profusely. The *ala nasi* were working and the lips were cyanosed. The patient appeared to be in great pain and had a slight cough. Her respirations were a little accelerated and of unequal amplitude, expiration being accompanied by a grunting noise. She was restless and did not sleep, even under the influence of heavy doses of morphine, but she continually cried out and talked in an incoherent manner. No family history and no past history were obtainable.

On examination of the patient, the pulse rate was found to be increased (120 beats per minute), and the pulse was

regular in time and amplitude. Her temperature was 100° F. and her respirations numbered 30 per minute. The tongue was slightly coated and dry. The abdomen was a little distended and did not move on respiration. It was tender to palpation, and muscular rigidity was present over the whole abdomen, which was hyperresonant on percussion. Discontinuous râles were audible at the bases of both lungs. Both lower limbs were completely anaesthetic from the hips down, and on palpation were cold. They were covered with diffuse blue blotches. The knee jerks and plantar reflexes were absent. No pulsations were present in any of the arteries of the lower limbs (*dorsalis pedis*, posterior malleolar, popliteal and femoral). The patient had no control whatsoever over defaecation or micturition.

At 4 a.m. on July 3 the patient's condition became worse. The pulse rate increased to 180 beats per minute. The amplitude of the pulse became smaller, but the rhythm remained regular. The maximum blood pressure was 140 millimetres of mercury and the minimum pressure 90. The skin over the lower extremities did not pit on pressure, although both limbs appeared a little swollen.

At 9 a.m. the pulse became barely perceptible and was irregular in time and amplitude. The blood pressure was too low to be recorded with the sphygmomanometer. The patient died at 10.40 a.m.

Post-Mortem Examination.

A post-mortem examination was made on July 3. Post-mortem staining and *rigor mortis* were present. The thyroid gland, mediastinum and thymus were normal. Both lungs were bound to the walls of the thoracic cavity by fairly dense fibrous adhesions. Both lungs were congested, and hemorrhagic infarcts of varying size were scattered throughout them. Part of the base of the left lung was deflated. No pulmonary emboli were found. The left lung weighed 300 grammes and the right lung 500 grammes.

There was a slight excess of fluid in the pericardial cavity. The heart was larger than normal. The right side was dilated. The right auricle contained a large amount of agonal clot. The mitral valve was stenosed and admitted one finger. The edges of the cusps were thickened by dense nodules of fibrous tissue and were bound together. There was nothing to suggest recent endocarditis. The left ventricle was a little dilated. The wall of the ventricle was two centimetres in thickness, and there was some increase in subpericardial fat. The aortic valve was competent. Some atheroma of the aorta was present. The coronary arteries were slightly atheromatous. The heart weighed 550 grammes.

Eight ounces of blood-stained fluid were present in the peritoneal cavity. The spleen was enlarged. At the upper pole there was an infarct, which was of a greyish colour, but of soft consistency. In the substance of the spleen a recent hemorrhagic infarct was present. The weight of the spleen was 230 grammes.

Examination of the liver disclosed chronic venous congestion; the organ weighed 1,450 grammes. The kidneys were congested. Throughout the substance of both kidneys there were recent hemorrhagic infarcts. The capsule stripped with difficulty, petechial hemorrhages being revealed. The left kidney weighed 130 grammes and the right kidney 150 grammes.

The stomach and intestines were dilated, and in the walls of the latter congestion of the blood vessels was apparent. Early moist gangrene of the mucous membrane of the lower seven centimetres of the rectum was found; the affected area was of yellowish-green appearance. No ulceration or sloughing had occurred. The pancreas was normal. The suprarenals were congested. Congestion of the blood vessels of the bladder wall was present. The genitalia were normal.

The abdominal aorta was occupied by an ante-mortem thrombus. This extended from just below the origin of the renal arteries and passed down both common iliac arteries as far as their bifurcations. Below this the arteries were filled with post-mortem clot. The clot extended evenly throughout the vessels and completely filled them. No rolled or twisted clot resembling an embolus was seen. The general appearance suggested rather that the clot had been formed *in situ*. Behind the upper part of the clot was an atheromatous ulcer with some calcification. The appearance suggested that clotting started at this point and extended downwards.

Discussion.

Differential Diagnosis.

In all cases of aortic thrombosis involving the renal, mesenteric or hemorrhoidal vessels, symptoms referable to

the organs supplied by these vessels will be present, together with the other symptoms. In the differential diagnosis, perforated peptic ulcer, with its sudden pain, shock and board-like condition of the abdomen is excluded by the lack of a history suggestive of ulcer and by the absence of pulsation in the vessels of the lower limbs.

Intestinal obstruction manifests itself in colicky abdominal pain, shock and faeculent vomiting, which is usually profuse when the obstruction is high, the abdominal distension being greater when the obstruction is lower. Profuse vomiting and pronounced distension are never seen in aortic thrombosis, while the pain is not colicky in character.

Ruptured ectopic gestation would be difficult to exclude, because in this condition the stabbing—and on occasions constant—pain in the lower part of the abdomen, together with shock and signs of internal hemorrhage, may simulate aortic thrombosis. If the hemorrhage was profuse and the shock was severe, then the vessels in the lower limbs might well not be palpable; but the contrast between the circulation in the lower and the upper limbs, the presence of anæsthesia in the lower limbs, the absence of a palpable swelling on vaginal examination, and the absence of pronounced pallor or syncope would serve to differentiate the two conditions.

The gastric crises of *tabes dorsalis* may simulate the picture of aortic thrombosis on account of the absence of knee jerks, the pain and the prostration; but the presence of the Argyll-Robertson pupil, a history of previous attacks, the absence of paralysis and the presence of pulsation in the lower limbs in *tabes* will exclude that condition.

The more slowly developing cases of aortic thrombosis may simulate Raynaud's disease; but the extensive involvement of the lower extremities, the progressive character of the lesion, and ultimately, the lack of pulsation in the femoral arteries rule out Raynaud's disease.

In cases of aortic thrombosis without much pain, acute myelitis may be suggested; but the pallor of the skin, the coldness of the lower extremities and the absence of pulsation in the vessels of the lower limbs should prevent this mistake.

Acute pancreatitis may simulate aortic thrombosis, as in the former condition sudden intense pain in the abdomen and prostration are present. However, the absence of much vomiting, the reference of pain to the lower extremities, and the lack of pulsation in the lower limbs, together with paralysis, should lead to the diagnosis of aortic thrombosis.

Aneurysm of the abdominal aorta usually takes the form of a sacular aneurysm near the origin of the celiac axis artery. The patient may complain of abdominal or lumbar pain, which is continuous and intensified when he lies down, and the femoral pulses may be obliterated. However, a pulsating, expansile swelling can usually be detected on palpation.

If dissecting aneurysm of the abdominal aorta is present, the patient usually complains of sudden abdominal pain and prostration. The condition is caused either by rupture of one of the *vasa vasorum* with the formation of a hæmatoma, or more usually by separation of an atheromatous plaque, which allows blood to insinuate itself between the inner and the outer parts of the muscular coat. It is usually discovered only at post-mortem examination, unless leakage causes symptoms suggestive of an abdominal catastrophe, when it may be disclosed at laparotomy. Once the process of dissection starts, it may pass down into the abdominal aorta and even into the iliac arteries. The aneurysm may rupture into itself or outside, and in some cases it may heal, truly bearing out Osler's remark that it is "the most remarkable reparative process seen in the human body".

The pathological background thus indicates that the symptoms may vary enormously, and this condition would be extremely hard to differentiate from aortic thrombosis; but a sudden and symmetrical arrest of circulation in the lower extremities without evidence of extravasation or signs of hemorrhage (low blood pressure, pallor *et cetera*), and survival of the patient for twenty-four hours or more, would point to aortic thrombosis. A noteworthy feature of the case here reported was the fact that the blood pressure as registered in the upper limbs remained normal until shortly before death, or even became elevated (140 millimetres of mercury, systolic, and 90, diastolic); this elevation of blood pressure was accompanied by pronounced acceleration of the pulse.

Comment.

If the condition is of gradual onset, the patient may live two, three or even four years after the onset of symptoms. If the onset is acute, the outlook is exceedingly bad. Death may take place within twenty-four hours; the end usually occurs within two weeks.

In this case the cause of death presents an interesting problem. Shock may be suggested as the cause of death; but the true picture of shock was not present until the patient was about to die.

Shortly after her admission to the hospital at Port Macquarie, the patient's maximum blood pressure was 125 millimetres of mercury and her minimum pressure 70, and her pulse rate was 94 per minute, which was quite a normal recording; the patient presented no sign of shock, although she was sweating at the time. Dr. Murphy even comments on the fact that the patient "was not shocked", and as no one was reasonably close to perform an embolectomy, he thought that her condition justified the long trip to Sydney.

Shortly after her admission to the Royal Prince Alfred Hospital, her maximum blood pressure rose to 140 millimetres of mercury and her minimum pressure to 90, and the pulse rate rose to 180 per minute; this rather suggested that two factors were present, operating one against the other.

In normal circumstances increased blood pressure would cause a slowing of the pulse by reason of the carotid sinus and aortic reflexes; but in this case the pulse was accelerated, although the blood pressure rose. Could the increased pulse rate have been caused by an increased venous return stimulating Bainbridge's reflex? If the two iliac arteries were occluded, this would mean a loss in blood supply to the limbs, and the venous blood already there together with the tissue fluids would be returned to the smaller circulating tree; thus the active blood volume in it would be increased and the heart rate would be accelerated through Bainbridge's reflex.

Daly⁽¹⁾ has demonstrated by means of a closed-circuit heart-lung preparation that an increase in the volume of the circulating blood produces, with the exception of minor differences, the same effect as an increase of venous inflow in the open-circuit heart-lung preparation. In one experiment the blood pressure increased as the blood volume was increased, but gradually fell towards the end, despite the fact that more blood was being added to the circulation.

In the present case the effect of increased venous return upon a damaged heart, the seat of mitral stenosis and auricular fibrillation, might have been to cause exhaustion and ultimate failure of output with a terminal fall in blood pressure.

Pulmonary congestion, which was found at the post-mortem examination, is unlikely to have been the immediate cause of death, as insufficient fluid was present at the bases of the lungs to make this likely; it may, however, have accounted for some symptoms, such as dyspnoea and slight cyanosis.

Toxæmia may have played a part in causing death. Abnormal metabolism in the tissues of the devitalized limbs may lead to the evolution of toxic substances poisoning the heart or vital centres. However, the signs of toxæmia, such as elevation of body temperature, wasting, dry coated tongue, anæmia and albuminuria, were absent.

Acknowledgements.

I wish to express my thanks to Professor C. G. Lambie for his advice and encouragement.

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- (2) Mazoux: "Thrombose de l'aorte", *Thèse de Paris*, 1905.
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ENTEROSTOMY IN PARALYTIC ILEUS FOLLOWING A RUPTURED APPENDICEAL ABSCESS.

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Clinical Record.

A.C., a rural labourer, aged thirty-seven years, was brought to me on November 1, 1943, with severe lower abdominal pain of two days' duration. He admitted having had a similar attack of pain two months previously, which had lasted several days. On the previous morning, when the

pain became severe, he had taken about an ounce of castor oil, followed several hours later by one ounce of Epsom salt. He had vomited three times, and the pain had become steadily worse in the right lower abdominal quadrant.

On examination of the patient, the temperature was 98.6° F. and the pulse rate 88 per minute. Acute tenderness was present in the right iliac fossa, but the abdominal musculature was quite soft and relaxed, and no mass could be felt. The temperature and pulse rate remained constant for about an hour, but shortly afterwards the temperature rose one degree and the patient complained of very severe pain.

Under local anaesthesia, the peritoneum was opened through the usual grid-iron incision, and a large quantity of free fluid was found. Below the inflamed caecum there was a thick-walled abscess cavity, the wall of which had been ruptured, and through which could be seen a necrotic appendix, perforated at its mid-point and lying in thick, offensive pus. This was removed without difficulty, powdered sulphanilamide was sprinkled around the area, and the abscess cavity was drained through the wound.

Immediate post-operative treatment included the administration of full doses of sulphonamides by mouth and 1.5 litres of saline solution and 5% dextrose solution by the continuous intravenous drip method. On the second day, he received intramuscular injections of 0.5 cubic centimetre of pitressin every four hours for four doses, and the drainage tube was removed; that evening he vomited three ounces of brown fluid, and except for a slight emesis after the second operation, this was the only occasion on which any vomiting occurred. At this time a moderate degree of distension was present. A small glycerin enema on the third day was returned slightly coloured, and a little flatus was passed. His condition was otherwise good, and from this time on until the ninth day he maintained a normal temperature and pulse rate. During the next five days, enemata were given each morning with negative or indifferent results; each day the degree of distension became greater. Saline solution (17%) given slowly by intravenous injection had no appreciable effect. In accordance with the trend of current pharmacological teaching, morphine in doses of one-sixth of a grain was administered every four hours in an attempt to promote intestinal tone. On the fifth day, a Rehfsuss tube was inserted through the nose and left in position until the seventh day, gastric aspiration being carried out every hour; normal saline and dextrose solutions were given intravenously to a further six litres. By the ninth day, the distension was pronounced, and the measurement around the abdomen at a point just above the umbilicus was 39 inches, the patient being normally of rather lean build. Four milligrammes of "Aneurin" were given intramuscularly in divided doses, and later in the day severe abdominal pain was felt, and the temperature rose to 100° F. On the tenth post-operative day, I felt that, despite a natural prejudice against enterostomy in paralytic ileus, the tonus of the distended gut must by now be so impaired that drainage of the small bowel offered the only prospect of restoring it to normal functioning.

Under local anaesthesia, an upper left paramedian incision was made, and the first presenting loop of distended small intestine was carefully deflated with trocar and cannula. A rubber tube was tied into the bowel, being invaginated by two concentric purse-string sutures. The tube, having been drawn through omentum, was then brought out through a stab wound to the left of the paramedian incision.

During the next few days, the patient received a gradually increasing diet, sulphonamides by mouth, vitamin K with bile salts, and vitamin B₁. The distension disappeared within four or five days, and since the fifth day the bowels have functioned normally and well. Gross sacral oedema and a collection of fluid at the base of the left lung, both presumably resulting from the intensity of the abdominal distension, also cleared away quickly. The enterostomy tube drained freely until the sixth day, when it was removed; there was no further fecal drainage, and the stab wound has healed well.

Summary.

A case of enterostomy carried out successfully for the relief of an intractable and increasing distension following a ruptured appendiceal abscess is described, and a short résumé is given of various methods which were unavailing used prior to surgical intervention.

It is hoped that the rapid relief obtained in this instance of paralytic ileus by drainage of the gut may add slightly to present statistical evidence concerning the management of this condition.

Reviews.

SURGICAL ANATOMY.

LEE MCGREGOR in his "Synopsis of Surgical Anatomy" has collated a great deal of useful information.¹ Notable omissions include the surgical approach to the blood vessels and Henry's approach to the ulnar synovial sheath. Strangely enough, the surgical anatomy of sympathetic ganglion injections is omitted, although the clinical aspects are discussed. From the list of abnormal bands is omitted the genito-mesenteric fold of Read (*Journal of Anatomy*, 1911).

To make room for these, much already in the book could be left out, for example, the discussion on pulmonary tuberculosis which has more to do with surgery than with surgical anatomy. The same may be said about the section dealing with the etiology and treatment of hypertension.

Inaccuracies abound: the description of the ligament of Treitz as arising from the side of a vertebra; the inclusion of *peau d'orange* amongst the "retractions" in relation to cancer of the breast; the stated length of the small bowel, 23 feet, whereas in the living it is six to twelve feet (see Alvarez); the definition of azygos as "a median unpaired structure"; the statement that the tooth in its socket is the only example of a gomphosis, which ignores the detailed structure of the cranial sutures.

Inaccurate and misleading drawings include Figure 98, which shows the vertebral column at birth, quite misshapen; Figure 142, which shows the subscapular muscle inserted into the greater tuberosity of the humerus; Figure 639, which shows a vertical extension of Kocher's subcostal incision not illustrated by Kocher in his text-book. Figure 640 shows the seventh, eighth and ninth intercostal nerves radiating from a central point, an arrangement contradicted in Figure 642. Figure 681 is badly drawn and shows Langenbeck's incision on an aspect of the elbow joint which resembles the anterior rather than the posterior. In the discussion on Kocher's approach to the elbow joint the remarks about nerve supply are not anatomically accurate.

In the section on amputations there is much to which exception may be taken. On page 632 it is directed that the femur be measured "from the perineum and not from the trochanter", but on page 636 the measurement is taken from the trochanter. The author refers to the old rule that the skin flaps should equal the diameter of the limb, whereas the old rule specified diameter and a half. Crushing and ligating could be omitted in the treatment of nerves, and stripping of the periosteum in the treatment of the bone. The author's enthusiasm for the old tarso-metatarsal amputation is not shared by most surgeons.

The descriptions of the radiographic appearances of polycystic kidney and of horse-shoe kidney are misleading. The explanation given in Figure 389 of the obstruction caused by an aberrant renal artery is quite wrong, and the diagram grossly offends in showing the kidney on a plane anterior to the vertebral column.

The part dealing with the hand makes no mention of the important relationship between the distal digital flexion crease and the end of the synovial sheath. The author's horse-shoe incision for felons could be improved by preserving the skin at the tip of the finger. It is very doubtful whether his antero-lateral digital incision would avoid the digital nerves.

The discussion on the McBurney incision for appendicectomy is not sound. The downward extension of the incision in the rectus sheath is a useful and harmless procedure. The nerves supplying the muscles of the conjoined tendon can easily be avoided by moving the incision slightly to the left and upwards.

The author is very fond of eponyms, and most of the names will mean nothing to the reader. It would be better if a small biographical note was given with each of these. Our final complaint is that the Venus de Milo is labelled a hyposthenic.

The indictment here given is not quite so bad as it looks, because it includes but a small proportion of the facts brought together in the book. The book may be of use to those students who prefer small pieces of "tabloid" knowledge, illustrated by diagrams of geometrical pattern.

¹"A Synopsis of Surgical Anatomy" by Alexander Lee McGregor, M.Ch. (Edinburgh), F.R.C.S. (England); Fifth Edition; 1943. Bristol: John Wright and Sons Limited. London: Simpkin Marshall (1941) Limited. 7½ x 5", pp. 725, with many illustrations. Price: 25s.

The Medical Journal of Australia

SATURDAY, MARCH 11, 1944.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: Initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

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THE MEETING OF THE FEDERAL COUNCIL.

THE Federal Council has met once more and has devoted long hours to the discussion of matters of vital importance to the whole medical profession, and, we would add, to the whole of the people of the Commonwealth. It will be seen from the short report of the proceedings published in this issue that the major subjects discussed were closely related, though this relationship may not at first be obvious. From the comments that are sometimes made on the Federal Council and its works, it is apparently necessary to point out that the report published in this journal is and can be little more than a summary of the proceedings which included three whole days of crowded discussion. The object of the report is to give members of the association as comprehensive an idea as possible of the important matters at present occupying the attention of all who are engaged in the medico-political arena. Not long ago it was suggested in all seriousness by responsible and prominent members of the association that the report of the Federal Council meeting published in the journal should end with a summary. To publish a summary of what is already a summary would in our opinion be of little value. At present it is our custom to draw attention in a leading article to the main features of what has happened at Federal Council meetings. This and the published report are the pabulum with which members of the association should try to appease their appetites for medico-political news.

The three major subjects of the recent meeting, closely related, as already remarked, were medical planning, the powers of the Federal Council and the general secretariat. The process of planning for the future of medical practice is a lengthy business and, as readers are probably well aware, is also causing much discussion in the Old Country and in other parts of the Empire. As a matter of fact Australian planners are waiting somewhat impatiently to learn details of the "white paper" which has been issued

in Great Britain in connexion with the future of medical services in that country—details of the same kind have been discussed in England and in Australia, and the state of affairs is not likely to be very different in the two countries. The Federal Council of the British Medical Association in Australia has been busy with medical planning for some considerable time. Some progress has been made and members of the association are well aware of the principles which in the Federal Council's view should underlie any medical service in the future. It was in the process of laying down these principles that the Federal Council inquired into its power to bind the several Branches in the matter of its decisions. Clearly if the Federal Council was to be the mouthpiece of the Branches, it wished to know whether, in the absence of complete agreement among the Branches, the decisions of the majority would be binding on the whole. To understand the question it is necessary to remember the history of the Federal Council. At the risk of repeating what most readers know, we may remind them that in the early years of this century the several Australian Branches of the British Medical Association were isolated entities which seldom, if ever, had official dealings with one another. There were in Australia two separate medical journals, and though Australian doctors met every few years at congresses, these gatherings had nothing to do with the British Medical Association; their continuity was for all practical purposes dependent on the life of the man who at one congress was appointed as president-elect of the next. The inauguration of the Federal Committee in 1913 was an obvious necessity, but it was also an act of faith in the future of Australian medicine. Two immediate and obvious results followed the establishment of the Federal Committee. The two journals then being published were discontinued by those controlling them—the New South Wales and Victorian Branches—and THE MEDICAL JOURNAL OF AUSTRALIA came into being, its first number being published on July 4, 1914, just one month before the outbreak of war, under the editorship of the late Henry William Armit. The second result was the inauguration of the Australasian Medical Congress under the aegis of the British Medical Association. The war of 1914-1918 caused the postponement of the first of the congresses until 1923, when the first session was held in Melbourne with the late George Adlington Syme as president. But in addition to these two obvious and important results, there was another more subtle, steadily increasing and of immense value in a country which was making rapid strides in its growth to manhood. It was the discovery of a common feeling between the Branches and their members, a new sense of destiny shared by them all, and a knowledge that they had to live and work in concert and not in isolation if they were to make the most effective contribution to the health and welfare of the community. Probably this was at first quite vague, but there is no doubt that as the years passed the desire for united and effective action became stronger. It was thus that the Federal Committee was superseded by the Federal Council, a body which everyone believed and hoped would have greater freedom of action in initiating and giving effect to legislation than its predecessor had enjoyed. As members of the Branches are aware, the Federal Council has been content to remain as a consultative and coordinating body, although its members may have had other ideas of its powers. As one of the members pointed out at the

recent meeting, much valuable work has been done since the Federal Council was formed. If no move had been made to obtain a legal opinion, there would have been no question of a disturbance of the *status quo*. As matters stand, the Council, if it wishes to have powers to bind the Branches, will have to persuade the Branches to adopt a new constitution and even then the respective powers of the central Council and of the Branches would have to be determined. Many persons will ask whether it would be advisable to "bind" a Branch to carry out certain decisions if it was not willing to be bound. There is no doubt that willing action is of much greater value and is likely to be much more lasting than action taken under compulsion. In the circumstances the Branches will surely agree that the Federal Council made a right decision when it decided not to seek new powers.

As the Federal Council is not to seek fresh powers, it follows that its present organization must be exploited to the full in an effort to obtain unity of outlook and of action. Such a unity would mean an absence of parochialism and the adoption in all the States of a federal outlook. This does not mean the elimination of the rights of all State Branches, as certain people seem to think, but it does mean that federal considerations, the good of Australia as a whole, should be the general guiding principle in all decisions; the wishes of the States can and should be made to harmonize with the larger considerations wherever this is possible. In the promotion of the federal outlook and for the fuller instruction of the Branches in the significance of new happenings and projects the recent developments in the secretariat will take a great part. Already the General Secretary has visited the Queensland Branch and has addressed the Victorian and South Australian Branches; visits to Western Australia and Tasmania are contemplated for the near future. This is the kind of development that is needed. In the present urgent state of general medical practice, with doctors in every centre working almost to the limit of their endurance, it will not be possible for practitioners in many parts of a State to journey to the capital city to hear the General Secretary's expositions and exhortations. It is to be hoped that in these circumstances meetings will be arranged for him at least in the larger country centres.

This brings us to the question of medical planning which may be linked with the two subjects already discussed by the statement that more careful organization should be expected to result in keener appreciation of the diverse problems associated with planning. At the Federal Council meeting the Branches were taken to task because, with the exception of Victoria, they had not indicated what form of controlled scheme would be acceptable if control was forced on the profession. It will be noted that the Council took what may appear to be an unusual course of action. It discussed the fee-for-service scheme adopted by the Victorian Branch "as one acceptable substitute for any unacceptable scheme proposed by this government" and made certain alterations in the resolutions covering it, as well as some omissions. It then decided to submit to the Branches, not its own altered form of the resolutions, but the original resolutions of the Victorian Convocation. By doing what they have done, the members of the Council cannot be regarded as trying to force their own view on the Branches. And in any

case the Federal Council had to discuss the Victorian fee-for-service scheme in some detail before it decided what action it would take. The account given by the President, Sir Henry Newland, of the conference at Canberra with the Parliamentary Joint Committee on Social Security is disappointing. It was certainly hoped that the National Health and Medical Research Council would send its representatives to the conference when the suggestion that the Federal Council and the National Health and Medical Research Council should meet for discussion came from the ranks of the latter body. It is a little difficult for people unversed in Canberra and its ways to understand the reasons behind the National Health and Medical Research Council's disappointing action. That the representatives of the practising profession and the members of the Parliamentary Joint Committee were able to reach agreement to matters of principle is important. In this regard special attention should be drawn to a report of the Parliamentary Joint Committee which it is hoped will shortly be published in this journal. That a section of the daily Press saw fit to publish misleading statements about an agreement being reached between the British Medical Association and the Commonwealth Government on a health service for all Australia is disappointing but not wholly unexpected. When no Australian newspapers publish inaccuracies about the British Medical Association, the millennium will have arrived.

Under the heading of medical planning the pharmacy benefit scheme of the Commonwealth Government was discussed by the Federal Council. The bill dealing with this scheme is under consideration at Canberra as this issue of the journal goes to press. As our views regarding the measure have already been published no further reference will be made to it. Many other matters are mentioned in our report of the Federal Council's meeting, but with our short discussion on the three related subjects we shall for the time being rest content.

Current Comment.

INCAPACITATING ILLNESS AMONG MERCHANT SEAMEN.

BEFORE the war no one thought or talked much about the prowess of the merchant marine, and few people took trouble to inquire into the health and living conditions of seamen. The war has brought a change, and most people agree that the courage of the men of the merchant navy, as it is now called, cannot be too highly praised. But whether a war is being waged or not, the health of seamen has to be maintained. A "life on the ocean wave" is in reality a much more humdrum and strenuous affair than aspiring youth is led to believe in the tales of rollicking adventure that he reads. As a matter of fact the true sailor has a love of the sea that in the past has made him put up with conditions which should not have been tolerated. Many medical men love the sea, but apart from this their interest in preventive medicine will not allow them to pass by a report on the health of seamen. Alexander Hutchison, who is port boarding medical officer at Glasgow, has published a short account of 5,374 cases of sickness among merchant navy personnel that had to be dealt with during the two years, May, 1941, to May, 1943, by the port boarding medical officers of the Glasgow Port Health Authority.¹ The cases dealt with

¹ *The Lancet*, December 11, 1943.

occurred while ships were at anchorage and do not include cases of sickness found among crews on their arrival in port. For this reason it will not be correct to regard the illnesses as being really representative of those affecting sea-going personnel. While the sailors were in port living conditions on the ships would be unchanged, but food might be better or more varied, though this would not necessarily be the case. More alcohol would be consumed than when the crews were at sea, and this fact might have a bearing on the incidence of trauma and venereal disease. In regard to respiratory conditions infections would probably be picked up more easily during shore leave than they would in a ship's crew that was at sea for any considerable length of time; much might depend on the latitude of the seas that were sailed.

Turning to Hutchison's statistics, we find that among the 5,374 cases of illness there were 1,057 cases of infectious disease (19.7% of the total), 973 cases of trauma (18.1%) and 3,344 cases of systemic disease (62.2%). The several items under these headings are set out in a table, and from this table Hutchison selects the following as being the chief contributors to incapacity among merchant seamen: infectious disease, 515 cases (9.6%); venereal disease, 542 cases (10.1%); trauma, 973 cases (18.1%); bronchitis, 254 cases (4.7%); defective teeth, 230 cases (4.3%); gastritis, 267 cases (5.0%); skin diseases, 827 cases (15.4%); scrimshanking, 191 cases (3.6%). Of the 19.7% of all sickness represented by infectious disease, including venereal disease, 2.5% were due to tonsillitis and 3.3% to influenza. These diseases, it is stated, are spread by close contact in overcrowded forecables. It is to be noted that bronchitis is mentioned separately and is named as chief among the respiratory diseases. The aetiology is vague, but the various types may be related to a respiratory infection, dusty atmospheres, extremes of heat and cold or psychoneurotic components. The steps suggested by Hutchison to control these conditions include: reduction of overcrowding in forecables; the provision of more isolation accommodation aboard the ship; education of masters in the high infectivity of the diseases, especially of tonsillitis and influenza; prevention by medical examination of any person suffering from tuberculosis from adopting service in the merchant navy as a career; better ventilation and removal of dust from stokeholds; the prevention of men from coming direct from stokeholds or warm kitchens into the open; the general improvement of the welfare and morale of the ship's company. It was found that the incidence of tuberculosis was four times as high as among miners and fully one and a half times as high as the relative incidence of the disease among the civilian male industrial population.

Venereal disease accounted for 10.1% of all incapacity; though this figure is high, it is known not to include all cases. Among the measures recommended to reduce the incidence are two of importance—the examination of all seamen before embarkation and disembarkation with a view to the institution of treatment and the adoption of prophylaxis. Hutchison also has pertinent remarks to make on trauma and skin disease.

Some of the illness among sailors arises from the conditions of life at sea. Conditions have been improved recently in the newer ships, but it is common knowledge that living accommodation in the older vessels is anything but good. This is in general just as true of Australian ships as of those on British articles. Food should be of good quality and well cooked. Hutchison mentions an outbreak of enteritis on a ship. On investigating it, he learned that the cook's only previous occupation had been that of a cement mixer, that he had had no training in cooking and that he boiled the ship's laundry in the urns used for making the crew's tea. Those who live and work in Australian ships do not look with favour on the food that is supplied to them or on the way in which it is cooked and served. We understand that an inquiry into this subject is about to be made by the Maritime Industry Commission. On the score of hours of work there is nothing to complain about from the health point of view,

for all ships are now worked on the three shift principle of four hours on duty and eight off. It would be of interest to have a report something like Hutchison's on the health of seamen in Australian ships; such a report would be of value in plans to lessen the incidence of illness among them.

THE TREATMENT OF CARRIERS OF MENINGOCOCCI BY SULPHADIAZINE.

AN investigation of the use of sulphapyridine in eliminating meningococci from the fauces of carriers was conducted in 1939 by Meehan and Merrillees. Their report was published in this journal in the issue of July 27, 1940. They administered one gramme of sulphapyridine per stone of body weight per day for five days, then suspended the drug for five days, then repeated the treatment over another period of five days. The results obtained by them were satisfactory; the carrier rate fell to zero, and cerebrospinal meningitis, which had broken out at intervals since 1937, ceased to occur in the institution. Various observers in other parts of the world have confirmed the findings of Meehan and Merrillees. In the light of present-day knowledge it would seem that the doses used by Meehan and Merrillees were unnecessarily large. For this reason, as well as for the information it contains, a report by F. S. Cheever, B. B. Breese and H. C. Upham on the use of one of the less toxic sulphanilamide compounds is of interest.¹ During an outbreak of meningitis in a naval barracks they took swabbings from the throats of 1,004 men and cultured meningococci from 579 of them. They treated 203 men, 161 of whom were infected, with sulphadiazine in a dose of three grammes on the first day, three grammes on the second day, and two grammes on the third day—a total of eight grammes in three days. On the fourth day swabbing of the naso-pharynx was repeated; but in no case could the organisms be grown in culture. On the seventh day a culture was obtained from one man; but as the organism was of a different type it was thought that he had been reinfected. Another group of 186 men, 108 of whom were carriers, were untreated. On the fourth day of the investigation the rate of infection among these men had risen from 58.06% to 80.64%; on the seventh day it was 76.35%. The men in both groups lived under the same conditions and they messed together.

Swabbing was repeated on the thirty-seventh day, when of 90 men who had received treatment, only 18 (20%) were found to have been reinfected. The carrier rate among 134 of the group of untreated men at the same time was 81.3%. Cheever, Breese and Upham concluded from these results that: "Carriers successfully treated with sulfadiazine became reinfected relatively slowly after the withdrawal of the drug in spite of constant exposure to the specific organism." This conclusion is scarcely justifiable without some evidence as to the normal rate of increase in the proportion of carriers. The men felt quite well while taking the drug. No toxic effects were noted. The urine was examined microscopically twelve hours after the withdrawal of the drug and was found to contain no blood or abnormal crystals. Facilities for determining the level of sulphadiazine in the blood were unavailable.

The results of this investigation show that meningococcal naso-pharyngeal infection in carriers can be almost if not wholly eliminated by small doses of sulphadiazine. The question arises whether this treatment is necessary or practicable. It is not practicable to treat the population as a whole; but it is practicable and advisable to treat the members of a household in which a case of cerebrospinal meningitis has occurred. The treatment of carriers was both practicable and necessary in the foundling hospital where it was used by Meehan and Merrillees. In large camps or barracks where meningococcal infection exists carriers might be sought and treated; and groups of men about to leave for duty elsewhere should be treated whether facilities for determining infection are available or not.

¹ *Annals of Internal Medicine*, October, 1943.

Abstracts from Medical Literature.

PHYSIOLOGY.

The Eccentricity of Standing and its Cause.

F. A. HELLEBRANDT, B. G. NELSON AND E. M. LARSEN (*The American Journal of Physiology*, November, 1943) describe a series of experiments designed to yield quantitative estimates of right-sided and left-sided differences in size, strength and limb preference performed on a small group of young adult women in an effort to elucidate the mechanism of the slight postero-sinistral eccentricity of the vertical projection of the centre of gravity of the body as a whole which characterizes the upright stance of 80% of normal subjects. The evidence substantiates the following conclusions: morphological and functional asymmetries occur in limb preference, volume and strength, and although most of the observed asymmetries are too small to have statistical significance, they constantly favour the right side. It is suggested that in the aggregate these small dextral asymmetries in functional capacity associated with like differences in strength and size have the effect of a slightly eccentric counterweight on the incessantly shifting rotatory movements acting on the joints of the weight-bearing skeletal parts. The autonomous equilibrating muscular contractions called forth over-compensate for the force of this eccentric weight and the anteriorly unbalanced position of the leg by an amount great enough to result in a slight eccentricity in the location of the mean vertical projection of the centre of weight in a position contralateral to the sum of the unequal stresses.

Rapid Acclimatization to Work in Hot Climates.

S. ROBINSON, E. S. TURRELL, H. S. BELDING AND S. M. HORVATH (*The American Journal of Physiology*, November, 1943) report that during the winter, experiments were carried out in which men walked on a motor-driven treadmill from one to one and a half hours a day in a room where desert conditions were simulated. When the men first began to take the walks the work was severe enough and sufficiently long to bring on symptoms of heat exhaustion. The comfort and ease with which the men repeated the same walks which originally exhausted them increased rapidly during about seven days and thereafter more slowly up to twenty-three days. The heart rates of the men during the latter part of the walks declined from an average of 178 per minute in the beginning to 155 on the seventh day. The average skin temperature and rectal temperature of the men at the end of the work experiments declined from 98.4° to 96.5° F. and from 103.4° to 101.7° F. respectively during the same period. This rapid improvement in temperature regulation during the first seven days amounted to about 80% of the entire improvement in 23 days. It was accompanied by an increase in the rate of sweating in one man and decreases

in metabolic rate during work in the others. The slow improvement in temperature regulation occurring after the seventh day was not accompanied by continued lowering of metabolic rate nor by increase of sweating during the experiments. However, the capacity for sweating in harder work than that in the standard experiments did increase.

The Vasopressor Effect of Thermal Trauma.

W. H. OLSON AND H. NACHELES (*The American Journal of Physiology*, August, 1943) give the following summary of some work done on dogs. During and following burns a rise of blood pressure occurred and in many experiments the pressure remained high for a considerable period of time following the burn. This rise in blood pressure may give misleading information concerning the condition of the animal. Scalding of a denervated foot caused a slight drop in blood pressure; scalding of the normal foot resulted in a marked rise in blood pressure. Splenectomy did not abolish the pressor effect of burns. Adrenalectomy and splanchnectomy failed to abolish the pressor effect of a burn. Animals whose hypophysis had been removed exhibited a marked fall in blood pressure when burned, the opposite of the response of normal animals. The acetylcholine vasopressor response was inhibited in severe burns. A pressor substance could be demonstrated in blood from burned animals, but part of its effect seemed to be due to hemolysis. Renin was excluded as a major factor in the vasopressor effect of burns. The rise of blood pressure following burns seems to be due to a combination of several factors, nervous, hormonal and hemolyzed blood.

The Peripheral Visual Acuity of 100 Subjects.

F. N. LOW (*The American Journal of Physiology*, October, 1943) reports the employment of a new test for peripheral visual acuity. The hundred subjects examined gave a great variety of results, the total scores running from 43% to 364% of the average of the whole group. The author suggests that peripheral visual acuity is an independent visual function. He also found that the weaker the peripheral visual acuity for any point, the greater is the variation for that point. Evidence obtained during the course of the work suggests that peripheral visual acuity can be trained.

The Drinking of Sea Water by Rats.

E. F. ADOLPH (*The American Journal of Physiology*, October, 1943) discusses the results obtained when attempting to maintain rats with sea water as their only source of drinking water. Albino rats survived slightly longer, while losing the same amount of body water, when allowed to drink sea water than when denied all water. Inclination and ability to ingest and metabolize sea water varied among individuals. The concentration of chloride in urine was in some individuals greater than that in the sea water. These high concentrations do not occur in man or dog or marine mammals. The rats gained water from ingestion and subsequent excretion of salts slower than they lost it by evaporation. Half sea water, or

equivalent solution of sodium chloride, allowed indefinite maintenance of body weight in rats, with augmented turn-overs of water and salt. Maintenance of water content was not favoured by progressive increase in the salt concentration of drinking water. Recovery from dehydration as a result of previous water privation did not occur when sea water or equivalent concentration of sodium chloride was allowed. When fresh water was given the corresponding recovery required several days' time.

The Basal Metabolism of College Women.

MARTHA S. PITTMAN *et alii* (*The American Journal of Physiology*, October, 1943) report that basal metabolism determinations have been made on 1,179 college women from five mid-western States. These represented 576 different individuals ranging in age from seventeen to twenty-four years, inclusive. The basal rates for the different States were significantly different. Something more than temperature in the geographical regions represented is needed to explain the differences in basal rates, although it would seem to have some influence. In general, the rates were lower in warmer climates. Body temperatures were lower than the accepted standards for subjects in all the States represented in this study. Little correlation was evident for basal metabolism with body temperatures, respiration or pulse rates. Yearly tests on the same subject over a three to five year period indicated that intraindividual variations tended to mask any changes from year to year due to age.

The Effect of Caffeine and Coffee Extract on the Activity of the Digestive Enzyme.

FLORENCE WALKER (*The American Journal of Physiology*, July, 1943) reports the result of an examination of the effect of caffeine and an extract prepared from roasted coffee upon the rate of enzymatic action in the case of amylolytic, proteolytic and lipolytic digestions. Caffeine, when present in concentrations of 20 milligrammes and 40 milligrammes per 100 millilitres of substrate, showed absolutely no effect on the activity of any of the enzymes studied, namely, salivary and pancreatic amylases, pepsin, trypsin and pancreatic lipase. The coffee extract likewise was without effect on the proteolytic enzymes, pepsin and trypsin. It was recognized, however, that the concentration of hydrochloric acid necessary for the activity of pepsin doubtless altered the nature of the coffee extract, and in the experiments, it was not the effect of the original constituents of the coffee that was determined, but of the products formed by the acid treatment. But since this acidity is comparable to that of the gastric juice, in which medium pepsin acts *in vivo*, it may be assumed that coffee undergoes similar changes in the stomach and would produce a similar effect on the action of pepsin *in vivo*. The experiments showed, however, a decided increase in the rate of digestion by both salivary and pancreatic amylase when coffee extract was present. Since this favourable influence is not due to the caffeine present, it must be attributed to some

other of the many constituents of coffee. Coffee extract in the two concentrations studied does not affect the digestion *in vitro* of casein by pepsin or trypsin.

BIOCHEMISTRY.

Iron Absorption.

P. F. HAHN *et alii* (*The Journal of Experimental Medicine*, September, 1943) have investigated iron absorption using radio-active iron. Iron absorption is a function of the gastrointestinal mucosal epithelium. The normal non-anæmic dog absorbs little iron, but chronic anæmia due to blood loss brings about considerable absorption, perhaps five to fifteen times normal. In general the same differences are observed in man. Sudden change from normal to severe anæmia within twenty-four hours does not significantly increase iron absorption. As the days pass new hemoglobin is formed. The body iron stores are depleted and within seven days iron absorption is active, even when the red cell hematocrit reading is rising. Anoxæmia of 50% normal oxygen concentration for forty-eight hours does not significantly enhance iron absorption. In this respect it resembles acute anæmia. Ordinary doses of iron given one to six hours before radio-iron will cause some "mucosa block", that is, an intake of radio-iron less than anticipated. Many variable factors which modify peristalsis come into this reaction. Iron given by vein some days before the dose of radio-iron does not appear to inhibit iron absorption. Plasma radio-iron absorption curves vary greatly. The curves may show sharp peaks in one to two hours when the iron is given in an empty stomach, but after six hours when the radio-iron is given with food. Duration time of curves also varies widely, the plasma iron returning to normal in six to twelve hours. Gastric, duodenal or jejunal pouches all show very active absorption of iron. The plasma concentration peak may reach a maximum before the solution of iron is removed from the gastric pouch, another example of "mucosa block". Absorption and distribution of radio-iron in the body of growing pups give very suggestive experimental data. The spleen, heart, upper gastro-intestinal tract, marrow and pancreas show more radio-iron than was expected. The term "physiological saturation" with iron may be applied to the gastro-intestinal mucosal epithelium and explain one phase of acceptance or refusal of ingested iron. Desaturation is a matter of days, not hours, whereas saturation may take place within one to two hours. The authors believe this change is a part of the complex protein metabolism of the cell.

Shock.

F. L. ENGEL *et alii* (*The Journal of Experimental Medicine*, May, 1943) have reported significant changes in amino acid and carbohydrate metabolism during and following the production of shock by hæmorrhage in the normal, suprarenal-demodulated and suprarenal-ectomized rat. In the intact, suprarenal-demodulated and

suprarenal-ectomized rat there is a progressive rise in the whole blood and plasma amino acid nitrogen levels during and after a fatal shock-inducing hæmorrhage. The rate of rise varies inversely with the survival time. In animals surviving the hæmorrhage there is little or no elevation in the whole blood amino acid levels during the eight hours following hæmorrhage, and a decrease in twenty-four hours due to hæmodilution. The plasma amino acids, however, rise slightly. The blood amino acid nitrogen elevation occurs only after the blood pressure has fallen to between 85 and 90 millimetres of mercury. The levels of blood keto acids, as pyruvate, and the blood lactate level become elevated during shock in the normal, suprarenal-demodulated and suprarenal-ectomized rat. In the normal fasted rat with low liver glycogen stores the blood sugar may rise moderately or may not rise at all during hæmorrhagic shock. In animals with high liver glycogen levels (fed rats or fasted rats previously fed on high protein diets) shock generally induces a marked hyperglycæmia. In both groups hypoglycæmia may occur terminally. In the suprarenal-demodulated and suprarenal-ectomized rats shock is always accompanied by a fall in the blood sugar. There is no significant difference between the liver glycogen level of suprarenal-demodulated rats fasted for forty-eight hours and that of rats similarly fasted but surviving twenty-four hours after a hæmorrhage. The blood chemical changes have been interpreted as due to a decrease in hepatic function resulting from early anoxia of the liver, and to the later effects of anoxia on the peripheral tissues, causing an increased rate of protein breakdown and of glucose utilization and an accumulation of lactate and pyruvate in the blood and tissues.

Phospholipides.

M. FISHLER *et alii* (*The Journal of Biological Chemistry*, September, 1943) have investigated the role of the liver in the formation of plasma phospholipides. Radio-active phosphorus as inorganic P32 was injected into normal and hepatectomized dogs and its recovery as phospholipide P32 was compared in these animals. Plasma phospholipides are formed mainly in the liver. Excision of the liver reduced the recovery of phospholipide P32 of the plasma to very small quantities. The recovery of phospholipide P32 in kidney and small intestine was not reduced by excision of the liver. Apparently phospholipides synthesized by these two tissues are not readily available to the plasma.

Scurvy.

D. W. WOOLLEY and L. O. KRAMPITZ (*The Journal of Experimental Medicine*, November, 1943) have investigated the production of a scurvy-like condition by the feeding of a compound structurally related to ascorbic acid. The feeding of gluco-ascorbic acid, an analogue of ascorbic acid, to mice and cooton rats caused the production of a condition exhibiting many of the changes characteristic of scurvy as seen in susceptible species. The condition was not prevented or cured by ascorbic acid, but was cured by the removal of the gluco-ascorbic acid from the diet. The condition was produced

in mice fed with a highly purified ration. It was not produced in mice fed with a natural ration. The presence of a substance in certain plant products which prevented the production of the condition was demonstrated.

Serum Phosphorus.

A. FREE and J. LEONARDS (*The Journal of Biological Chemistry*, July, 1943) have determined the changes in blood glucose and serum inorganic phosphate content in eight normal human subjects at intervals following the ingestion of 0.6 gramme of glucose per kilogram of body weight. Similar studies were carried out after oral and intravenous administration of the same quantities of galactose. A decrease in the serum inorganic phosphorus content and urinary excretion of phosphorus occurred in all of these studies. Serum inorganic phosphorus content decreased following the oral and intravenous injection of 0.6 gramme per kilogram of body weight of galactose or xylose in normal dogs. Comparison of the changes of serum phosphorus content following the oral and intravenous administration of galactose and xylose indicates that the process of intestinal absorption of the sugar does not influence the decrease in serum phosphorus content. Indirect evidence is presented to show that xylose is metabolized by the dog, although the rate of metabolism is slower than that of glucose or galactose.

Riboflavin.

H. SPECTOR *et alii* (*The Journal of Biological Chemistry*, September, 1943) have investigated the role of riboflavin in blood regeneration. Dogs were kept on a highly purified synthetic ration supplemented only with the crystalline B vitamins, exclusive of riboflavin. Blood analyses were carried out at various levels of riboflavin feeding, with and without phlebotomy, and the rate of hemoglobin regeneration was followed. Food consumption was poor and irregular in a deficiency of riboflavin and typical symptoms were observed. For good food consumption and good growth in young dogs a level of 30γ per kilogram of body weight per day was the minimal requirement. In adult dogs 15γ may be sufficient for good food consumption and maintenance of body weight. A mild anemia developed on a synthetic ration without riboflavin and severe anemia was readily induced with slight bleeding. The dogs cannot recover from this anemia unless riboflavin is fed. Only a slight and variable hemoglobin production was observed below a level of 15γ per kilogram of body weight per day in growing dogs; 30γ were necessary in growing dogs for good hemoglobin production and rapid recovery from anemia. The adult dog was able to show good hemoglobin regeneration at a level of 15γ per kilogram daily. An adult dog can maintain a normal hemoglobin level under the strain of phlebotomy with 15γ per kilogram daily. The hematopoietic response in growing dogs on 30γ was not sufficient to replace the blood removed. In the absence of riboflavin a microcytic, hypochromic type of anemia was produced. During phlebotomy with riboflavin feeding there was a normocytic, hypochromic type of anemia. Riboflavin plays a role in determining the size of new cells.

British Medical Association News.

MEETING OF THE FEDERAL COUNCIL.

A MEETING of the Federal Council of the British Medical Association in Australia was held at the Medical Society Hall, Albert Street, East Melbourne, on January 31 and February 1 and 2, 1944, SIR HENRY NEWLAND, the President, in the chair.

Representatives.

The following representatives of the Branches were present:

New South Wales: Dr. George Bell, O.B.E., Dr. W. F. Simmons.

Queensland: Dr. T. A. Price, Dr. A. E. Lee.

South Australia: Sir Henry Newland, C.B.E., D.S.O., Dr. R. J. Verco.

Tasmania: Dr. C. Craig, Dr. J. S. Reid.

Victoria: Dr. F. L. Davies, Dr. H. C. Colville.

Western Australia: Dr. N. M. Cuthbert, Dr. F. W. Carter.

Minutes.

The minutes of the previous meeting of the Federal Council of August 23, 24, 25 and 26, 1943, which had been circulated amongst members, were taken as read. In one of the resolutions quoted in the minutes an alteration had been made, to make the intention of the Federal Council clear. It was decided after discussion that the original form of the resolution should be retained. The minutes were then signed as correct.

Death of Dr. G. C. Anderson.

The President referred to the great loss that the whole Association had suffered in the death of Dr. George Cranston Anderson, who had been an officer of the Parent Association for twenty-four years. He had served as assistant medical secretary from 1919 to 1932 and as secretary from 1932 until 1944. The President said that a cable had been sent to the President of the Association. On the motion of Dr. W. F. Simmons, seconded by Dr. George Bell, it was resolved:

That the Federal Council place on record its appreciation of the distinguished services rendered by the late Dr. G. C. Anderson to the British Medical Association and to the profession.

Appointment of Office-Bearers.

Only one nomination had been received for the position of President, that of Sir Henry Newland, who was declared elected. For the office of Vice-President only one nomination had been received, that of Dr. George Bell, and Dr. Bell was declared elected. Only one nomination had been received for the position of Honorary Treasurer, that of Dr. George Bell, and Dr. Bell was declared elected.

Finance.

Dr. George Bell presented the financial statement and balance sheet as at December 31, 1943. The statement, which included the Federal Council account and the Australasian Medical Congress (British Medical Association) fund account, was received.

Dr. Bell also presented the financial statement of the national health insurance emergency fund. The statement was received. Dr. H. C. Colville asked how the money in the fund might be spent, and Dr. George Bell replied that as the fund was collected for a specific purpose, he thought it could be used for that purpose only. It was then resolved on the motion of Dr. George Bell, seconded by Dr. H. C. Colville, that a legal opinion should be obtained regarding the possibility of using the money in the fund for organization purposes. Dr. R. J. Verco said that he thought it would be necessary to ask each contributor whether he agreed that this should be done.

Dr. George Bell submitted a statement setting out the contributions made by the Branches to the general expenses of the Federal Council, and containing an estimate of the credit balance at December 31, 1943. The statement was adopted.

Recompense to Federal Representatives Attending Conferences et cetera.

At the instance of the Western Australian Branch, the Federal Council considered the recompense to Branch repre-

sentatives who attended federal conferences et cetera as representatives. The General Secretary reported that he had sent the Western Australian letter on to the several Branches, but that owing to the shortness of the time only one Branch, Victoria, had replied, and in this instance the reply was not in favour of any payment to be made by the Federal Council. Dr. F. W. Carter explained the position from the Western Australian point of view. He referred to the great difficulty that was being experienced in the obtaining of *locum tenentes*. Not only were they difficult to obtain, but there was a great deal of variation in the training and experience which some *locum tenentes* had had. The question also arose regarding the interval of time that elapsed between the arrival of the *locum tenens* and the departure of the principal. Dr. Carter held that unless something was done to assure federal representatives that their practices would be properly cared for in their absence, any representatives who were general practitioners might be compelled to resign their appointments as Branch representatives on federal bodies. Dr. Carter also referred to the attitude of some medical officers from the services regarding the question of fees. Dr. George Bell said that the New South Wales Branch had not had an opportunity of considering the matter, but his personal opinion was that some steps should be taken to comply with the Western Australian suggestion. Dr. A. E. Lee expressed the opinion that the State Branch was responsible for any additional expenses incurred by its representatives, and pointed out that the Queensland Branch paid its representatives two guineas a day when they were attending authorized conferences. Dr. F. L. Davies said that he had been instructed by his council to vote against the proposal. Dr. T. A. Price wondered whether some priority in the matter of *locum tenentes* could not be established.

After further discussion the Federal Council adopted a resolution authorizing certain payments to members of the Federal Council absent from their practices on authorized business of the Council, but at this stage Dr. H. C. Colville pointed out that the question was to have been considered by the Branches, but of members of the Council only he and Dr. Davies had received instructions from their Branch Council. The motion already passed was therefore rescinded, and it was then resolved on the motion of Dr. George Bell, seconded by Dr. W. F. Simmons:

That it be a recommendation to the Branches that a member of the Federal Council, whilst absent from his practice on authorized business of the Council, be paid by the Federal Council an amount of two guineas *per diem* in addition to the amount of thirty shillings *per diem* for living expenses in order to reimburse him for absence from his practice, and this resolution take effect as from January 1, 1944.

Dr. F. W. Carter said that he thought that the attention of the Branches should be directed to the Federal Council's decision regarding the fees payable to *locum tenentes*, and it was therefore resolved on the motion of Dr. Carter, seconded by Dr. N. M. Cuthbert, that the Branches and the Central Medical Coordination Committee should be reminded of the decisions of the Federal Council arrived at in March, 1940, regarding the fees payable to *locum tenentes*, namely, that it should be suggested to the Branch Council that the fees in question should be from 12 to 14 guineas a week.

Full-Time Secretariat.

At the previous meeting of the Federal Council consideration was given to the appointment of a full-time secretary. It was then resolved that the New South Wales Branch should be informed that the Federal Council was desirous of appointing Dr. J. G. Hunter as full-time General Secretary, and would like the Branch to release him from duty as Medical Secretary of that Branch. It was also at that meeting resolved that, subject to his release by the New South Wales Branch, Dr. Hunter should be appointed full-time General Secretary of the Federal Council.

It was reported that letters had been written to the several Branches and that the New South Wales Branch had been written to in terms of the Federal Council's previous decision. The New South Wales Branch had replied that it was willing to release Dr. J. G. Hunter if the Federal Council required his services on a full-time basis. The Branch thought, however, that unless the matter was very urgent, the release should be a gradual process. Dr. George Bell explained the attitude of the New South Wales Branch, and said that while the Branch was willing

to release Dr. Hunter for full-time duty with the Federal Council, it did not believe that the work was yet sufficient to occupy the whole of his time. The Branch therefore suggested to the Federal Council that Dr. Hunter's services should be available on the following basis, namely, that he should spend six months in visiting the Branches on Federal Council business, and that the remaining six months of his time should be spent at the office in Sydney, where his services would be available both to the Federal Council and to the New South Wales Branch. Dr. W. F. Simmons referred to the financial aspects of the proposal and pointed out that as matters stood, Dr. J. G. Hunter was General Secretary of the Federal Council and Dr. Hugh Hunter was his assistant. In his opinion Dr. J. G. Hunter should be the General Secretary of the Federal Council and Dr. Hugh Hunter an officer of the New South Wales Branch only. Dr. A. E. Lee agreed that the transfer of Dr. J. G. Hunter from part-time to full-time duty with the Federal Council should be a gradual process; the Queensland Branch was in favour of such a procedure. Dr. N. M. Cuthbert thought that the recommendations of the New South Wales Branch Council should be accepted. Dr. H. C. Colville thought that the arrangement was an excellent one from the Federal Council point of view, and added that the only difficulty would be that of assessing the amount of time spent in the duties of the two offices. It was resolved, on the motion of Dr. N. M. Cuthbert, seconded by Dr. F. W. Carter, that the recommendation of the New South Wales Branch should be accepted and that the arrangement should commence as from January 1, 1944.

During subsequent discussion, Dr. J. G. Hunter, in reply to questions, said that he thought Federal Council duties would occupy approximately two-thirds of his time. The Federal Council then resolved that Dr. J. G. Hunter should be part-time General Secretary of the Federal Council for the year 1944, and that Dr. Hugh Hunter's appointment as Assistant General Secretary should be terminated.

Decorations Received by Medical Officers of the Australian Armed Forces.

The General Secretary reported that on behalf of the President and the members of the Federal Council he had offered congratulations to the following members of the Australian armed forces who had been honoured by His Majesty the King: Brigadier F. K. Norris, C.B.E., D.S.O., Colonel J. G. Hayden, C.B.E., Lieutenant-Colonel A. F. Hobson, O.B.E., Lieutenant-Colonel E. C. Palmer, O.B.E., Captain A. E. McGuinness, M.C., Captain F. N. Street, M.C.

Scientific Cinematograph Films.

A letter was received from the Victorian Branch, stating that certain scientific films were available for use and might be obtained from the Department of Information. Reference was also made to films which were in the possession of certain chemical drug houses, and it was resolved that the information should be sent to the several Branches.

The Australian Dental Association.

The Victorian Branch forwarded a request of the Australian Dental Association for the support of the British Medical Association in its request that dental fees should be allowed as deductions for income tax purposes. On the motion of Dr. C. Craig, seconded by Dr. F. W. Carter, it was resolved that support should be given.

Housing Standards Committee.

The General Secretary reported that a request had been received from the Director-General of the Ministry of Post-War Reconstruction for the Federal Council to appoint a delegate who would attend meetings of the Technical Bodies Advisory Committee on Housing Standards. After consultation with the members of the Organization Committee, Professor Harvey Sutton was nominated as a delegate. On the motion of Dr. George Bell, seconded by Dr. W. F. Simmons, the nomination was approved by the Federal Council.

Workers' Compensation in South Australia.

A communication was received from the South Australian Branch in reference to recent amendments to the South Australian *Workers' Compensation Act, 1932-1941*. According to the amendments, matters in dispute were to be referred to a judge of the Supreme Court. The South Australian Branch had taken exception to this provision in the following letter to the South Australian Treasurer.

BRITISH MEDICAL ASSOCIATION.
(South Australian Branch.)

178 North Terrace,
Adelaide,

18th January, 1944.

The Honourable the Treasurer,
Flinders Street,
Adelaide.

An Act to Amend the Workmen's Compensation Act, 1932-1941.

Dear Sir,

Members of the Medical Board at Port Pirie under the *Workmen's Compensation Act, 1932*, have approached the Council of the Association in reference to the above amending Act recently passed by Parliament.

Under the *Workmen's Compensation Act of 1927* three members of the medical profession practising at Port Pirie were appointed a Board to consider every suspected case of lead poisoning, and the decision of the Board was final with no right of appeal either by employer or employee. This procedure has operated successfully.

In the Amending Act if a workman or the Smelting Company is aggrieved by the action of the Board in giving or refusing to give any certificate, or any other decision of the Board, the matter shall, upon request in writing by the workman or the Smelting Company to the Secretary of the Board, be referred by him to a Judge of the Supreme Court and his decision shall be final.

In the opinion of the Council, this Amendment is inequitable, unjust, and not in the best interests of the parties concerned for the following reasons:

1. The diagnosis of lead poisoning rests on the consideration solely of medical facts and not of "Evidence"; that no lay Court, therefore, can decide whether a man is or is not suffering from lead poisoning.

2. The opinion on such a question which should be least fallible is that which can be given by a round table consultation on a suspected case by medical practitioners who have most opportunities of seeing cases of lead poisoning.

3. If No. 2 above is correct, the decision of such consultation should be final, and there should be no right of appeal from it either to a single medical referee, or least of all, to a lay Court.

4. The new Amendment will produce a reversion to the little-to-be-desired legal controversies which appertained prior to 1928.

5. As a precedent in New South Wales, there is no right of appeal from the decisions of Medical Boards such as those established in connection with lead poisoning, silicosis and accidents.

In view of the opinions expressed above, the members of the present Board who also hold these opinions, having accepted nomination as Members of a Board whose decision shall be final, do not wish to continue to act under the new conditions. They do not, however, wish to resign forthwith, as by so doing, they would leave the employees with no legal machinery with which to obtain compensation for incapacity due to lead poisoning.

The Council respectfully suggests therefore for your consideration:

(a) that the Amending Act be repealed, and that the decision of the Medical Board shall be taken as final, in which case the present Board will continue to function, or

(b) failing this, that new legislation be introduced to enable the workman who is suffering from lead poisoning to obtain compensation, and thus allow the present Members of the Board to immediately tender their resignations.

Yours faithfully,

(Signed) E. A. H. RUSSELL,
President.

The President pointed out that the matter was one which primarily concerned the South Australian Branch; it also was the concern of the whole profession in Australia. After discussion it was resolved that the Federal Council should give its utmost support to the South Australian Branch, and a letter of protest should be forwarded to the South Australian State Treasurer.

Medical Officers' Relief Fund (Federal).

Dr. George Bell presented an interim report on behalf of the trustees of the Medical Officers' Relief Fund (Federal) for the half-year ended December 31, 1943. The report was received.

The Federal Medical War Relief Fund.

At the previous meeting of the Federal Council reference had been made to the establishment of a federal medical war relief fund. It was then resolved that the Minister should be approached with a view to securing an amendment of the *Taxation Act*, so that at the end of the war funds established for the relief of medical practitioners should not be subject to taxation. The General Secretary reported that owing to the exigencies of the political situation he had not been able to arrange an interview with the Attorney General, Dr. H. V. Evatt; he hoped to be able to do so in the near future. The matter was left in the hands of the General Secretary.

Australasian Medical Publishing Company, Limited.

The General Secretary reported that the agreement with the Australasian Medical Publishing Company, Limited, for the supply of *THE MEDICAL JOURNAL OF AUSTRALIA* had been completed and signed, and all that remained was to give effect to the agreement. He pointed out that under Clause IV the Federal Council was required to furnish to the company the names and addresses for the time being of the members of the Branches of the Association in Australia, and also that Clause VII required the Federal Council to pay to the company on the last day in January, April, July and October in each year a *per capita* payment of one pound for each annual subscription which each member had paid on such dates respectively. These functions had previously been carried out by the Branches, and if they were now to be carried out by the Federal Council, it would mean an unnecessary duplication of work, as the lists would have to be prepared by the Branches, sent to the Federal Council and then by the Federal Council to the company. On the motion of Dr. F. L. Davies, seconded by Dr. George Bell, it was resolved that the Branches should be appointed the agents of the Federal Council for the purpose of giving effect to the two clauses in question.

The General Secretary also reported that the articles of association of the Australasian Medical Publishing Company, Limited, had been altered in certain respects. The most important of these alterations had to do with the appointment of proxies by directors who were not able to attend meetings of the company. According to the amended articles, it will be possible for a director who is unable to attend a meeting to nominate a member of his Branch to act as his proxy, and this nomination will be accepted provided it receives the written approval of the President of the Branch.

The General Secretary also announced that the company had decided to continue its rebate to the Branches for the year 1944 of the sum of 10s. for each member who had totally relinquished civil practice at December 31, 1943, for continuous full-time service in His Majesty's forces. It was resolved that the company should be thanked for its generous action.

The financial statement of the company for the year ended June 30, 1943, was taken as read and received.

The Publicity Committee.

The reappointment of the members of the Publicity Committee of the Federal Council was discussed. In view of certain inaccurate statements which had appeared in the Press regarding recent medico-political activities of the Association, it was held that the appointment of a committee to deal with such questions was important. It was pointed out that at its previous meeting the Federal Council had resolved that some publicity by broadcasting might be undertaken, and it was therefore decided on the motion of Dr. C. Craig, seconded by Dr. N. M. Cuthbert, that the committee should no longer be called the Press Publicity Committee, but that the word "Press" should be omitted from the title. It was also resolved that Dr. George Bell and Dr. W. F. Simmons should be reappointed members of the committee. During a short discussion on the value of publicity by Press and radio, it was pointed out that the use of broadcasting would be a very expensive method of obtaining publicity.

Power of the Federal Council to Bind the Branches.

At its previous meeting the Federal Council discussed the relationship between itself and the several Branches. The

discussion arose originally from a suggestion of the Queensland Branch that steps should be taken by each of the Branches to transfer to the Federal Council powers to negotiate with the Federal Government. At the previous meeting the Federal Council had before it an opinion of Mr. F. W. Kitto, K.C., dealing with the whole matter. The Federal Council at that meeting resolved that each Branch should be asked to state "whether the Federal Council represented the views of the Branch on medical policy and was authorized to express those views". (This is the resolution referred to in regard to the minutes of the previous meeting.)

The General Secretary reported that he had written to the Branches. The South Australian Branch stated that the Federal Council did express the views of the Branch. The New South Wales Branch replied that the Federal Council's statements did represent the views of the Branch and that the Federal Council was authorized to express those views. The Victorian Branch replied that its members would accept the Federal Council's decisions only if the Branch had an opportunity to express an opinion regarding them. The Tasmanian Branch agreed that the statements of the Federal Council did represent the views of the Branch and that the Council was authorized to express those views. The Queensland Branch stated that in matters common to all the Branches the Federal Council was empowered to express the views of the Branch. The South Australian Branch in another communication stated that it was imperative that full powers should be granted to the Federal Council. While there was no legal obligation on the Branches, any Branch that did fail to follow the lead of the Federal Council would be acting prejudicially to the interests of the profession in Australia. The New South Wales Branch asked the Federal Council to state what additional powers it thought were necessary.

At this stage the President ruled that as the matter of the powers of the Federal Council was so closely bound up with the organization of the profession, the two matters should be considered together.

Dr. George Bell asked whether it was possible for the Federal Council to be appointed to act as agent for the Branches. On being told that this was not possible, he said that the only alternative was for the Branches to approve the formation of an Australian Medical Association with a constitution similar to that of the South African Medical Association (British Medical Association). Unless this was done medical practitioners in the future would work under a handicap. He therefore moved that the Branches should be asked to approve the formation of an Australian Medical Association (British Medical Association) with a constitution similar to that of the South African Medical Association (British Medical Association). The motion was seconded by Dr. W. F. Simmons, and on being put to the meeting was lost.

The General Secretary then gave an outline of the constitutional position. He said that the crux of the matter was whether the Branches were satisfied with the present arrangement. Had the Federal Council sufficient powers? If not, what powers did the Branches think that the Council should have? He was not in favour of cutting the painter with the Parent Body and having a constitution similar to that of the Canadian Medical Association. Canada had been influenced largely by the numbers of French practitioners in the Dominion. Moreover, the British Medical Association had never been very well organized in Canada. When reorganization was under discussion, the delegation from the Parent Body of the British Medical Association to Canada in 1924 advised, in view of all the circumstances, affiliation was the best thing that could be done in regard to Canada. The Canadian Medical Association was affiliated with the British Medical Association; its members were not quite cut off from the Parent Association. Much the same problem had arisen in South Africa, but it had been solved in a different way. The South African body was part and parcel of the British Medical Association. It might be wise to adopt the same type of organization in Australia; it would then be necessary to decide what powers belonged to the Branches and what powers belonged to the Federal Council. It did seem that if the present Federal Council was to be able to act without having to rely only on a moral obligation, it would have to have a constitution of its own. The Branches should be autonomous, but the Federal Council should have some constitutional backing. There were two possibilities—to remain as at present with the present constitution, or to form an entirely new body.

Dr. A. E. Lee said that the British Medical Association was originally a colonial organization, formed in the early days when the colonies had not the freedom of government

which they enjoyed today as dominions. In Australia no important advances in British Medical Association affairs had occurred since federation other than the establishment of the Federal Council. This would not have mattered had health not become so prominent a matter during the war. Now a new organization was desirable. He thought that the Parent Body ought to give complete autonomy to the Federal Council and the Branches. If a change was made, consideration should be given to the present method of representation of the Branches on the Federal Council. The Queensland Branch was in favour of proportional representation. Such representation might be on the following basis: New South Wales and Victoria, three representatives each; Queensland, South Australia and Western Australia, two each; Tasmania, one.

Dr. R. J. Verco asked what would happen if a Branch refused to join the Australian Medical Association. The General Secretary replied that any proposed change would be futile unless all the Branches joined. Dr. C. Craig said that he doubted whether the Federal Council required any further powers. The function of the Council was to coordinate and correlate the views of the Branches. It was a slow-moving organization, and the fact that it acted only after consultation was good. The Branches would have to do some hard thinking before they resolved upon a change. He did not think that the Branches would be any better off if a change was effected. Dr. F. L. Davies agreed with Dr. Craig, and said that the extra powers wanted by the Federal Council were not possessed by the Parent Body. If a separate association was formed, the problem of binding the Branches would still exist. Dr. H. C. Colville agreed with Dr. Craig, and said that it would be unwise to move in the direction of an upheaval, particularly in view of the doubtful state of the powers of the Commonwealth in regard to health matters. If the Federal Government was refused powers, the State Governments would continue to administer health legislation. It would be time enough to consider any important change in the constitution of the Branches when fresh powers were acquired by the Commonwealth. Dr. Colville described as almost an accident the fact that a legal opinion had been obtained by the Federal Council. Had that opinion not been obtained, the Council would have gone on functioning as it had in the past, and would have continued to do good work. Dr. W. F. Simmons said that it was necessary to look at the standing of the Federal Council in the public eye and in its relation to external bodies. The Federal Council could not go on just as it had done since the days of the national health insurance discussion. It was impossible to obtain a decision on any matter for a period of up to two years. The present difficulty did not arise so much when the Council was conferring with other bodies without commitment; but the time was shortly coming when the Federal Council would have to make quick decisions. Unless the Council could really be what its members thought it was, it would be better for the several State Branches to retire from the Council and resume their own entities. It was necessary for the Council to "go on or sink". Dr. F. W. Carter supported Dr. Simmons. He said that State and Commonwealth powers had really no bearing on the matter. Until the Branches were able to act together, they would count for nothing in the political world. Dr. F. L. Davies asked what powers were wanted.

At this stage the General Secretary read a report furnished by Dr. Victor Hurley to the Federal Council after he had conferred with the executive of the Parent Body during his visit to England in 1938. In this report it was stated that in the opinion of the executive officers of the Home Association, the Association in Australia already had the power to do what it wanted to do under the present constitution; moreover, the Association in Australia could interpret the constitution liberally, and it was most improbable that any action taken by it would be questioned. If more power was desired, there was no doubt that it would be granted if a reasonable way of doing so by alteration of the constitution could be shown. The Parent Executive also thought that the Federal Council should explore the full possibilities of securing additional power from the several State Branches.

Dr. T. A. Price said that careful consideration would have to be given to the question before the idea of the formation of an Australian Medical Association (British Medical Association) was rejected. The formation of such a body would not interfere with loyalty to the Old Country, but would increase it. The powers of the Federal Council would always depend upon whether the Federal Council represented the medical profession, and it was no use trying to get powers for the Federal Council without trying to find out what the members wanted. It was for this reason

that he was so anxious that the General Secretary and other officers of the Federal Council should from time to time pay visits to the Branches. The Council was authorized to call up from the Branches a *per capita* payment of 21s. *per annum*, and he thought that the full amount should be called up in order that visits to the Branches might be paid. Dr. Price was not in favour of a legal agreement if the sole purpose of such an agreement was to bind the Branches to a decision of the Federal Council which they could not accept. Dr. C. Craig agreed with Dr. Price, and said that the whole thing depended upon the spirit of any agreement between the Branches and the Federal Council. If the proper spirit existed, there was no need for a legal agreement. Dr. Craig asked again what advantage it would be to the Federal Council to gain extra powers.

Dr. H. C. Colville said that he wanted to bring the discussion from the realms of the theoretical to those of the practical. Those in favour of the suggestions that had been made were in favour of unanimity of action when there was no unanimity of opinion. He therefore asked the following question: "If the Federal Council had all the powers which were envisaged in the proposals that had been put forward, and it was known that the Federal Government was about to introduce some form of national service, and the Council was asked to negotiate with the Government, what would be its attitude if three of the Branches agreed and three disagreed on a certain line of action? Further, what would be the position of the member of a Branch that dissented from an otherwise unanimous decision of the Federal Council? Would he be compelled to abide by the Council's decision?" Dr. W. F. Simmons answered that in such a case obviously there would be an impasse. It was his opinion, however, that the majority should rule.

The President said that the issues were plain. Did the Council believe that the Association in Australia should have self-government while they maintained their association with the Parent Body? If so, what should be the nature of the constitution? At the present time, if any matter was discussed, it was submitted to the Branches; the Branches replied to the Federal Council, which made its decisions according to the views expressed by the Branches, but it had no power to enforce such decisions. In his opinion no powers would be obtainable except under a new constitution. He thought that it was necessary for the Association in Australia to have self-government under a constitution properly and legally drafted, and he held that such an arrangement would have nothing but a good effect. Dr. N. M. Cuthbert thought that some change was necessary. It was essential to have an association which was independent, and the Council should investigate the possibilities of the formation of an Australian Medical Association the inauguration of which should be timed to synchronize with the institution of a general medical service for Australia. Dr. A. E. Lee agreed that some change was necessary, but said that the Federal Council should proceed step by step in obtaining additional powers. In his opinion additional powers that were needed were mostly executive and had a federal bearing. He therefore moved, and Dr. W. F. Simmons seconded, the following motion:

That the Federal Council desires additional executive powers to be determined by its legal advisers, but in general to be executive powers in matters under negotiation and common to all Branches.

Dr. C. Craig said that it was useless to ask for further powers unless some method of quick consultation with the Branches was devised. Dr. T. A. Price said that no Branch would give the Federal Council powers in matters which had not been considered by the Branch. Dr. H. C. Colville said that he agreed with the views of Dr. Craig; the Federal Council could not meet as often as it should, and in the near future frequent meetings would probably be necessary on account of the urgent problems that would arise. Financial reasons alone would preclude frequent meetings. Dr. A. E. Lee said that he deplored the utter nihilism that was being preached at the meeting. Dr. W. F. Simmons agreed with Dr. Colville that the question was bound up with finance and organization. The problems facing the Federal Council were much larger than those faced during the discussions on national health insurance. If the Federal Council was not prepared to meet frequently, it should cease to exist. Frequent consultations with the Branches were necessary; but in the final analysis the Federal Council would have to make decisions. Dr. Price said that the Federal Council had the necessary powers if it had found out the matters to which the Branches agreed. He added that the Federal Council should find out what the Branches needed, and with this the President agreed. Dr. George Bell said that the profession required an authoritative body, which should

be able to express the wishes of the profession as a whole. If this did not happen, State Branches would be found acting independently. Dr. N. M. Cuthbert said that it would be a waste of time to obtain further legal opinion. Dr. F. L. Davies said that matters should be allowed to remain as they were.

At this stage the President read the legal opinion that had been before the previous meeting of the Federal Council. Dr. George Bell said that what was required was unity in the profession. If the legal agreement was necessary, then a constitution similar to that of the South African Medical Association would have to be devised. Dr. F. L. Davies said that the profession would be far more united if it knew that the Federal Council had no legal power to bind the Branches. Dr. A. E. Lee, in reply to the President, said that in his opinion all that was necessary was that the Federal Council should have authority to speak on behalf of the Branches.

The motion moved by Dr. Lee and Dr. Simmons was put to the meeting and lost.

At this point the President referred to the request of the New South Wales Branch that the Federal Council should state what powers it required. After further discussion it was resolved on the motion of Dr. C. Craig, seconded by Dr. H. C. Colville:

That after the fullest discussion and inquiry, the Federal Council has come to the opinion that the present arrangement between the Council and the Branches, which is binding in honour only, is preferable to a legal agreement.

Organization of the Profession.

The General Secretary reported that he had visited Queensland on behalf of the Federal Council from November 10 to 26, 1943, that he had visited Victoria to address a special meeting of the Branch on January 13, 1944, and that he had addressed the South Australian Branch on January 15, 1944. The General Secretary also explained that he hoped to visit both Western Australia and Tasmania at an early date, but that owing to the political situation it was impossible to make any definite arrangements at the moment.

Mileage Charges.

At the previous meeting of the Federal Council the question of mileage charges was raised at the instance of the Queensland Branch. On that occasion the Queensland representatives suggested that the Queensland method for computing mileage charges should be adopted. According to this scheme, a charge was made for the service actually rendered to the patient, a sum was charged for the cost of travel at 1s. a mile and a fee was added for the time spent away from the practice. Sometimes other factors had to be considered, such as the dislocation of practice consequent on a call to a distance and risks associated with travelling, for example, travelling by air when proper landing grounds were not available. At the last meeting consideration of the matter was deferred. It was again resolved that consideration should be deferred.

The Contract Practice Committee.

The General Secretary pointed out that it was necessary to reappoint the Contract Practice Committee of the Federal Council, and it was resolved on the motion of Dr. George Bell, seconded by Dr. A. E. Lee, that the following should be members: New South Wales, Dr. H. R. R. Grieve; Queensland, Dr. L. P. Winterbotham; South Australia, Dr. R. J. Verco; Tasmania, Dr. J. R. Robertson; Victoria, Dr. C. H. Dickson; Western Australia, Dr. M. K. Moss; together with the President *ex officio*.

Contract Practice.

At the previous meeting of the Federal Council a deputation from the Consultative Committee of the Friendly Societies Association in Australia was received by the Council. This conference was held on account of difficulties that arose in the introduction of the Federal Common Form of Agreement into contract practice throughout Australia. The obstacle to the introduction of this agreement was the refusal of the Victorian friendly societies to fall into line with the other States in the adjustment of their annual *per capita* payment, although the Consultative Committee had given the Federal Council to understand that they would do so. The General Secretary explained that the Victorian Branch had refused to confer with the Victorian friendly societies until they had agreed to increase the *per capita* payment in accordance with the statement of their

Consultative Committee, and Dr. W. F. Simmons asked whether any further action had been taken. Dr. C. H. Dickson, who was present by invitation of the Federal Council, on being invited by the President to speak, said that the Victorian Branch would confer with the Victorian friendly societies when the increased rate was granted and when the Prices Commissioner agreed to the increase. The Victorian Branch Council's letter had been acknowledged by the friendly societies, and a week before the meeting of the Federal Council the friendly societies had again written, asking the Branch to meet them. In the letter, however, no undertaking in regard to the *per capita* payment was given, and the nature of the business to be discussed at the proposed conference was not disclosed. Dr. T. A. Price said that he thought that the Victorian Branch should meet the friendly societies. Dr. H. C. Colville said that the action of the Victorian Branch was the action advised by the Federal Council—namely, that as a preliminary to the introduction of the Federal Common Form of Agreement the capitation rate should be raised to equal the rate in New South Wales. The President asked whether the Federal Council could do anything to have an effect on the Victorian friendly societies. It was resolved on the motion of Dr. George Bell, seconded by Dr. C. Craig, that the correspondence should be received.

The National Health and Medical Research Council.

The Federal Council had before it a report by its representative of the sixteenth session of the National Health and Medical Research Council, held at Canberra from November 30 to December 3, 1943. The report was received.

Reference was also made to the constitution and functions of the National Health and Medical Research Council. In this regard the General Secretary explained that the body in question did a great deal of its work through committees. Thus it had a diets committee, consisting of Dr. Harold Ritchie, Dr. A. W. Holmes & Court, Professor Henry Priestley, Dr. W. F. Simmons and Dr. F. W. Clements. Dr. W. F. Simmons also explained that the research side of the committee's work was carried out on the basis of a reference committee, which comprised Dr. J. H. L. Cumpston, Professor H. R. Dew, Dr. Harold Ritchie, Professor M. L. Mitchell and Dr. W. F. Simmons. This committee dealt with all applications for grants and advised the Council in regard to the approval or disallowance of some line of research. The President said that the question of the constitution and functions of the National Health and Medical Research Council would be considered at the next conference with the Parliamentary Joint Committee on Social Security, and he reminded members of the Council that its attitude in the matter had been clearly defined, namely, that research should be divorced from other activities of the National Health and Medical Research Council.

Medical Planning.

Conference with the Parliamentary Joint Committee on Social Security.

The President made a statement about the conference on health services that was held at Canberra with the Parliamentary Joint Committee on Social Security on December 8 and 9, 1943. He said that at the previous meeting of the Federal Council, with the approval of the Council and acting in conjunction with the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians, he had acceded to the request of the Parliamentary Joint Committee on Social Security and had nominated six representatives of the medical profession to confer with six members of the National Health and Medical Research Council and with the Parliamentary Joint Committee. The six members were as follows: Sir Charles Blackburn, Dr. Victor Hurley, Dr. W. F. Simmons, Dr. F. L. Davies, Dr. F. W. Carter and himself, with the General Secretary, Dr. J. G. Hunter, in attendance. The President went on to say that he was later informed by the chairman of the Parliamentary Joint Committee, Mr. H. C. Barnard, that he had invited the directors of the medical services of the navy, army and air force to take part in the conference. The object of this invitation was to secure in some measure the views of those members of the medical profession who were absent on active service. Mr. Barnard also intimated that he had asked the members of the Medical Survey Committee to attend the conference.

The President said that in opening the conference, Mr. Barnard, the chairman, expressed his regret that the representation of the National Health and Medical Research Council was not as originally proposed and accepted. Dr. J. H. L. Cumpston alone attended, but not as a repre-

representative. The President said that in his reply to the chairman's opening remarks he shared the latter's regret that the six members of the National Health and Medical Research Council had not attended as originally arranged. He pointed out that the original suggestion that there should be a conference between the Federal Council and the National Health and Medical Research Council came from Dr. Cumpston himself. He stated that he had nominated members of the medical profession in the belief that such a conference would be held, and it was only since his arrival at Canberra that he had heard that representatives of the National Health and Medical Research Council would not be present. The President added that he then read the statement which he had prepared in conjunction with his colleagues. This statement was published in *THE MEDICAL JOURNAL OF AUSTRALIA* of December 18, 1943, at page 510.

The President explained that Dr. Cumpston had followed him, and had excused the non-attendance of members of the National Health and Medical Research Council on the score that the original invitation had been extended to take part in a discussion of a report before its presentation to Parliament; the invitation at the time was to discuss a report after its presentation to Parliament. Dr. Cumpston had then read a long statement prepared by the National Health and Medical Research Council, and the conference proceeded to discuss many matters dealt with in the report of the Parliamentary Joint Committee on Social Security. Many of the matters had obtained a large measure of approval, but differences of opinion arose when the question of general medical service came up for consideration.

Eventually the conference agreed that consideration should be given to the provision of a general medical service under conditions to be considered by a subcommittee of the conference, a medical planning committee.

The President explained that the Medical Planning Committee appointed by conference worked in three subdivisions. One subdivision of the committee considered medical services, another considered hospitals and a third considered health generally.

The General Secretary then read a report of the conference at Canberra on December 8 and 9, 1943, and also the reports of the Medical Planning Committee of the Parliamentary Joint Committee on Social Security drafted at its meetings held in Sydney on January 24 and 27, 1944.

At this stage the General Secretary referred to the misleading statements published in the Press in reference to the meeting of the Federal Council with the Parliamentary Joint Committee on Social Security, and he read the statement which was submitted by the chairman of the Parliamentary Joint Committee for publication in the Press. It was then that the Federal Council asked that a statement should be published in *THE MEDICAL JOURNAL OF AUSTRALIA*, asking members of the Association to give no credence to statements that had appeared in certain newspapers, to the effect that the British Medical Association had agreed with the Commonwealth Government on a health service for all Australia. This statement was published in the issue of February 5, 1944, at page 116. When the Secretary had finished reading the reports, he pointed out that no reference was made in them to the questions of control of the medical services, their administration or the method of payment. There was no indication as to how effect was to be given to the plans set out in the report. The Government held that the service must be free of charge to individual patients, except in regard to taxation. What the profession had to decide was whether it was willing to fit into this picture.

Dr. H. C. Colville said that he thought some definite resolutions dealing with the matter should be carried. He therefore proposed to submit to the Council for its consideration three motions which he thought might meet the case. He said that the report was acceptable as a document for the future. In regard to the present, he said that the medical profession had done a good job of work for the community, and that as far as he could gather there was no discontent with its achievements. There was no justification for the proposed service in the form of a public outcry or demand. He therefore moved as follows:

That the opinions expressed in the report of the Medical Planning Committee of the Parliamentary Joint Committee on Social Security concerning a comprehensive health service be approved as a possible policy for the future.

Dr. W. F. Simmons seconded the motion. He thought that the sooner the Federal Council expressed this view, the better. Dr. Simmons then went on to discuss the financial side of the question, and pointed out that the fund on which

the scheme was planned to depend had to cover a building programme and unemployment insurance as well as other forms of social legislation. It had been stated that the Government thought that 25% of the national income should be spent on matters connected with social welfare. This was possibly true for the present government, but it did not follow that every subsequent government would adopt the same view. Dr. C. Craig agreed that the report of the Medical Planning Committee should be adopted, because it embodied the general principles which had been laid down by the Federal Council. When the Federal Council objected to any change during the war, it should clearly state the reasons for its objection, namely, that many members of the profession were absent on active service, that civilian practitioners were too busily occupied to give much consideration to matters of medical politics, and also that it would not be possible for civilian practitioners to undertake any extra work at present. Dr. A. E. Lee said that while most of the report could be accepted, there were some parts on which agreement had not been reached, for example, group centres. The Council had previously opposed decentralized out-patient departments, and it would have to consider whether its opposition should continue. Dr. Lee referred to several clauses in the report. He referred particularly to the statement that under a system of voluntary participation general practitioners would retain their private practices and would nominate the number of half-day sessions they would be willing to devote to a general medical service on what would be in effect a part-time salaried basis. Success of a group scheme would depend on its availability to the public, and it would clearly be impossible for a general practitioner to compete against himself as the clause referred to suggested. Dr. Colville's motion was put to the meeting and carried.

Dr. Colville then moved his second motion. After discussion it was redrafted and put to the meeting in the following form:

That the Federal Council considers that the proposals of the Parliamentary Joint Committee on Social Security for out-patient and consulting clinics represents the first instalment of a drastic alteration in the form of medical service in the community, and is therefore strongly opposed to their implementation during the war and for one year afterwards. It does not, however, object to the immediate establishment of the experimental group practice centres suggested in the report of the Medical Planning Committee of the Parliamentary Joint Committee on Social Security.

The motion was seconded by Dr. W. F. Simmons and carried. It was then resolved, on the motion of Dr. H. C. Colville, seconded by Dr. W. F. Simmons:

That if any expenditure on health service is contemplated by the Commonwealth Government during the war period, the Federal Council strongly urges that it should be primarily to improvement of the hospital situation in terms of Paragraph IF of the report of the Medical Planning Committee of the Parliamentary Joint Committee on Social Security.

Dr. C. Craig asked whether the representatives who had to meet the Parliamentary Joint Committee on Social Security were satisfied with the Council's decisions in regard to medical planning, or whether they needed any further information for their guidance. Dr. F. W. Carter said that he wished to refer to the Government's financial policy. It was clear that the Government intended the socialization of medicine, and the Federal Council held the view that medical services should be available to everyone in the community. If the Federal Council did not agree with the Government's proposal that medical services as part of the social services of the community should be available to every person free of cost other than that paid by way of taxation, then the Council should have some other plan to put forward. The medical profession held that the individual in the community should pay something towards the cost of his medical care. The profession also held that the financial arrangements should be divorced from the general exchequer, and that a special fund should be established. The Government ought to be able to make the whole thing a paying proposition, and he believed that it would soon make an attempt to give effect to its plans for a medical service. The Government would negotiate with the medical profession, and the profession should be in a position to say on what terms it would give a service. The profession should impress on the Government the view that what was required was a better service with no alteration in the existing relationship between patient and doctor. Dr. F. L.

Davies said that when he returned after the Canberra conference, he had told the Victorian Branch Council that if it wished to have a fee-for-service system, it would have to put up a very strong case, as the members of the Parliamentary Joint Committee on Social Security were opposed to such a system. He added that the Victorian Branch convocation had met and had elaborated a scheme. The General Secretary referred to the necessity of the Branches advising the medical planning committee of their views on medical planning. Dr. H. C. Colville said that the Victorian Branch had clearly defined its policy at the convocation that was held a few days prior to the Federal Council meeting. In his opinion this was the most complete statement of policy formulated by any Branch. A short account of the meeting of convocation was published in the issue of February 26, 1944, at page 184. It was then resolved that the resolutions adopted by the Victorian Branch convocation should be considered.

The Federal Council, in considering the resolutions of convocation *seriatim*, omitted one or two which were obviously of a "domestic" character and could not be considered apart from the convocation itself. The resolutions of convocation that were before the Federal Council were, like the convocation agenda paper, divided into four sections. The first was an introductory section and contained two important statements, which had really been drafted on the Federal Council's previous resolutions. These were adopted. The second section had to do with the policy regarding a national medical service. The general purport of the resolutions in this section has been described in the report of the meeting of convocation. They were adopted by the Federal Council with two exceptions. The first of these had to do with any scheme for the extension of government control over existing general medical services to the community, or alternatively for a scheme for the addition of government controlled services to those already in existence. The Victorian convocation had resolved that administration should be in the hands, not of a government department, but of a corporate body, which should be composed of: (i) medical practitioners who should constitute a majority of the corporate body, elected by the practising medical profession; (ii) non-medical members of knowledge and experience in health matters nominated on a non-political basis. The Federal Council altered the first clause so that it should read: "Control should be in the hands, not of a government department, but of a Commonwealth corporate body. . . ." The second alteration in this section was in connexion with the convocation's resolution that any scheme for a national medical service should be financed by a special fund. The Federal Council altered the resolution so that it read: "That any scheme for a national medical service be financed by a special medical fund."

In the section of the resolutions of convocation dealing with policy in regard to the possible introduction of a national medical service by the Government, the Council deferred consideration of the resolution dealing with the fee-for-service system until it had considered in detail the last section of the convocation's resolutions dealing with that subject. Of the remaining resolutions in this section, two were not considered, as they had a domestic interest for the Victorian Branch only, three were accepted, and in one an alteration was made. The convocation had resolved that it was opposed to a nationalized salaried medical service, as it considered that it was not in the public interest that the medical profession should be converted into a salaried branch of the government service. The Federal Council, after discussion, altered the word "nationalized" to "socialized" so that the resolution read:

That the Federal Council of the British Medical Association in Australia is opposed to a socialized salaried medical service, as it considers that it is not in the public interest that the medical profession should be converted into a salaried branch of the government service.

Before the Federal Council considered in detail the last section of the resolutions of convocation dealing with a fee-for-service system, Dr. H. C. Colville said that he wished to explain to the Federal Council the purpose of the scheme. It will be remembered that the convocation regarded the scheme in the details considered by it to be "one acceptable substitute for any unacceptable scheme proposed by the Government". Dr. Colville pointed out that the resolutions in the last section dealing with a fee-for-service principle represented a brief summary of the chief points of the scheme which had been evolved by Dr. Charles Byrne and had been described by him in his book. The scheme was purely financial and was based on the view that there was

between the cost of medical services and the liability of the patient to pay for them a gap that should be bridged. The scheme would reduce the cost of medical services to the individual to approximately one-third of what it was at present. The private practitioner would still be engaged in private practice, and, for example, for a visit or consultation costing 10s. 6d. the patient would pay 3s. 6d. and the Government 7s. Similarly, for operations the patient would pay one-third and the Government two-thirds of the cost. The Federal Council, it appeared, would have to decide if it regarded a scheme put forward by the Parliamentary Joint Committee on Social Security as unsatisfactory, whether it would submit what Dr. Colville termed "the Byrne scheme" in its place. It would be seen that for doctors the scheme was voluntary, and that only those doctors participating in the scheme would be paid by it. Though it was possible that the number of doctors joining the scheme in the early days might be small, those who advocated it believed that in the long run all practitioners would join in. Its advocates also held that it would be of material help in the rehabilitation of medical practitioners from the services. According to the scheme, men returning from the services would have to be absorbed into practice before they could participate in the scheme. This meant that they would either have to start in practice on their own account, or be taken as assistant or partner by an established practitioner. It was held that there would be enough vacancies to absorb most of the service medical officers if practitioners were willing to make room for them.

The Federal Council then considered *seriatim* the resolutions dealing with a fee-for-service system. Some were accepted, two were amended and two were not approved. It was then moved by Dr. H. C. Colville and seconded by Dr. F. L. Davies that the scheme as outlined in the section should be approved, on the understanding that it should be advocated only as one acceptable substitute for any unacceptable scheme proposed by the Government. The motion was lost. It was then resolved, on the motion of Dr. H. C. Colville, seconded by Dr. F. L. Davies:

That the scheme outlined in the resolution of convocation, British Medical Association (Victorian Branch), January 28 and 29, 1944 (Section D, policy with regard to a national medical service conducted on the fee-for-service principle), be submitted to the Branches for their consideration of its use as one acceptable substitute for any unacceptable scheme proposed by the Government.

Dr. W. F. Simmons said that for the information and guidance of the representatives conferring with the Parliamentary Joint Committee on Social Security, he would like some direction from the Federal Council on the question of availability, administration and finance of a medical service to help the representatives go further in their discussions. After discussion it was agreed that the information contained in the resolutions previously passed on medical planning should for the time being be sufficient guidance for the representatives who were to confer with the Parliamentary Joint Committee.

Pharmacy Benefits Scheme.

The Federal Council had before it the proposed pharmacy scheme of the Commonwealth Government. The details of the scheme were set out in a memorandum sent by the Minister for Health to the President of the Federal Council in November last year. This memorandum was published in full in a leading article in this journal in the issue of January 22, 1944. The question was discussed at that time, and some account was given of an informal conference that took place on December 8, 1943, between the Minister and representatives of the British Medical Association. The General Secretary informed the members of the Council that a second conference had been held on January 30, 1944, the day before the meeting of the Federal Council. He also said that he had written to the Branches on the matter.

Dr. F. W. Carter, in discussing the scheme, said that it was proposed to provide pharmacy benefits, among others, to people previously unable to pay for drugs. It did not appear, however, that the scheme would do this, as patients would still have to pay for prescriptions which were not ordered within a formulary. The Director-General of Health had said that the cost would not count and that the object was to overcome polypharmacy. The members of the medical profession were alone able to decide what drug and what quantity of it was needed by the individual patient. The use of the formulary as set out in the scheme removed

from the medical practitioner the right to order what he thought was necessary for his patient. If cost was no consideration, why should a formulary be instituted at all? It was admitted that formularies served a useful purpose; but the profession could agree to a formulary only if there was no interference with the doctor's right to order drugs outside the formulary. Dr. Carter also insisted that if a formulary was used, bulk storage would probably occur, and this would inevitably carry with it depreciation of therapeutic value. Dr. F. L. Davies had no doubt that a great majority of the prescriptions ordered would be within the formulary; but that should not interfere with the right of the practitioner to order what he desired in the interests of his patient. Dr. Davies also referred to the duties which would be imposed on medical practitioners in the government scheme, in that they would have to write out the prescriptions in triplicate, and it would therefore be necessary for them always to carry with them prescription books with the necessary carbon sheets. The President said that the only dignified attitude for the profession to adopt was for it to decline to work within the formulary under the conditions laid down. It was then resolved on the motion of Dr. F. W. Carter, seconded by Dr. H. C. Colville, that the principle enunciated by the President at the conference with the Minister for Health at Canberra on December 8, 1943, should be affirmed.

It was further resolved on the motion of Dr. F. W. Carter, seconded by Dr. N. M. Cuthbert:

That provided the principle as enunciated by the President at the conference with the Minister for Health at Canberra on December 8, 1943, is recognized by the Government in its scheme for pharmacy benefit, the Federal Council will undertake to recommend to the members of the British Medical Association in Australia the fullest cooperation in the use of an official formulary.

The General Secretary said that a request had been received for the submission of ten names of members of the medical profession from which three would be selected to act as members of a formulary committee. It was resolved on the motion of Dr. A. E. Lee, seconded by Dr. T. A. Price, that provided the principle enunciated by the President was recognized, a panel of ten names should be submitted to the Minister. The Federal Council then chose ten names and authorized the President to add any additional names, should any of those chosen be unable to accept nomination. It was resolved on the motion of Dr. H. C. Colville, seconded by Dr. F. W. Carter:

That the Federal Council is of the opinion that the proposed pharmacy benefit scheme will not materially improve the health of the community and considers that the large expenditure involved in the project could better be devoted to other measures such as hospital construction and equipment, care and treatment of sufferers from tuberculosis, maternal and child welfare and diagnosis and treatment of cancer.

On the motion of Dr. N. M. Cuthbert, seconded by Dr. A. E. Lee, it was resolved as follows:

That in the interest of the patient it is essential that the practising medical profession be adequately represented on the controlling body, which should be statutory.

It was also resolved that if any further conference with the Minister for Health became necessary, the appointment of representatives should be left in the hands of the President.

Recommendations of the Representative Committee in England.

The Federal Council had before it a copy of the resolutions passed by the representative body of the British Medical Association at the annual representative meeting on September 21 and 22, 1943, in regard to the recommendations of the Representative Committee appointed at the invitation of the Minister of Health, England (see the *British Medical Journal*, October 9 and 16, 1943). The General Secretary said that the Medical Planning Committee of the Federal Council had considered the recommendations of the Representative Committee in England. It was of the opinion that it would be all to the good if the views of the profession in Australia coincided in the main with the views of the profession in Great Britain, especially in view of the fact that the profession in both countries had as its aim the improvement of medical services to the community.

The Medical Planning Committee of the Federal Council had therefore considered the recommendations of the Representative Committee and had amended them in the light of the principles and policy already laid down by the Federal Council. The amended statement was adopted on the motion of Dr. A. E. Lee, seconded by Dr. H. C. Colville.

Interim Report of the Medical Planning Committee of the Federal Council.

The General Secretary presented the interim report of the Medical Planning Committee of the Federal Council. Attached to the report were certain recommendations for the establishment of a comprehensive pathological service for Australia, together with a statement by the Australian and New Zealand Association of Radiologists in regard to post-war reconstruction. The report was received and approved. In order to facilitate the future work of the Medical Planning Committee, it was resolved on the motion of Dr. George Bell, seconded by Dr. F. L. Davies, that the terms of reference of the Medical Planning Committee of the Federal Council should be varied to provide for the cooption of five members instead of three.

Bankers' Health Society.

The General Secretary reported that he had received a special memorandum from Mr. A. D. Milne, General Secretary of the Bankers' Health Society. The memorandum covered the objects of the society and its procedure, as well as a proposal for the setting up of a fee-per-service system of medical benefit. The document, which went into the question of finance, was referred to the Medical Planning Committee of the Federal Council for its consideration.

The Electrolytic Zinc Community Council Health Service.

The General Secretary reported that he had received from the Electrolytic Zinc Company a scheme of health service for employees of the company, which, although not compulsory, was availed of by 98%. The correspondence was noted and the details were forwarded to the Medical Planning Committee of the Federal Council.

War Emergency Organization.

Conditions of Service Committee.

On the motion of Dr. George Bell, seconded by Dr. W. F. Simmons, Dr. F. L. Davies and Dr. H. C. Colville were reappointed members of the Conditions of Service Committee, with powers of cooption.

Repatriation Commission.

At previous meetings of the Federal Council consideration had been given to a proposed agreement between the Repatriation Commission and the Federal Council for the institution of a medical service for the benefit of widows, of orphans and of widowed mothers of men serving with the defence forces in the present war. At the previous meeting, the General Secretary reported that he had been unable to receive a reply from the Minister, and it was resolved that he should write again, pointing out that the old arrangement with regard to attendance was for a limited period only. The General Secretary now said that he had written to the Minister again, asking that finality be reached. Dr. Colville and Dr. Davies had interviewed the Minister, who had agreed to the amount of payment suggested, but had not agreed in regard to the clause requiring readjustment of the payment according to the basic wage index. The Minister had said that he was willing to revise the arrangement in two years' time. Dr. H. C. Colville pointed out that the work was going on and asked whether it was worth while proceeding in the matter. To this Dr. Simmons replied that Queensland was concerned, and that he thought finality should be reached on this account. It was resolved, on the motion of Dr. F. W. Carter, seconded by Dr. N. M. Cuthbert, that the Council should adhere to its original decision in the matter.

Rehabilitation of Medical Officers of the Armed Forces.

The rehabilitation of medical officers of the armed forces had been before the Federal Council at several of its previous meetings. At its last meeting the Council had decided to recommend to the Directors-General of the Medical Services that medical officers discharged from the armed forces be given three months' leave on full pay prior to their resumption of practice. It was noted that this recommendation had been sent on to the Central Medical Coordination Committee. The President said that this committee had been considering the rehabilitation of medical officers and the

question of post-graduate education for them. The General Secretary referred to the views of the Queensland and Western Australian Branches in the matter. Several of the members of the Council referred to the need that would be felt by medical officers at the end of the war for some financial assistance for their return to practice. Ways in which this might be arranged were discussed. Dr. W. F. Simmons referred to the organization known as Medical Finance Limited, and explained its method of working. The General Secretary read a letter that he had received from the Standing Committee of Services Medical Directors in reference to the question of permission being granted to medical officers released from full-time service in the forces, to notify the public through the Press of their resumption of practice. It was stated that such a procedure was permissible in all States but New South Wales, and it was suggested that the Federal Council should discuss the matter with the New South Wales Branch. In discussion it was pointed out that according to the rules of the New South Wales Branch, no member was permitted to make any notification of any kind in the Press regarding his absence from or return to practice. Dr. W. F. Simmons said that in the area of the Illawarra District Medical Association, when a practitioner returned from active service, a notice was displayed in the waiting rooms of the other practitioners in the area, stating that Dr. So-and-So had returned from active service, and it was the wish of his colleagues that his former patients should return to him. It was resolved on the motion of Dr. F. L. Davies, seconded by Dr. T. A. Price, that the letter from the Standing Committee of Services Medical Directors in regard to notifications of the resumption of practice in New South Wales should be referred to the New South Wales Branch.

The Notification of Dengue Fever.

At its previous meeting the Federal Council considered the fact that under National Security Regulations dengue fever had been declared a notifiable disease. It was also noted at that meeting that no fee was payable to the medical practitioner in respect of his notification, though it was customary that a fee should be paid in regard to the notification of other infectious diseases. The General Secretary had written to the Minister and had received a reply that the matter was under consideration. The General Secretary now reported that a regulation had been gazetted providing for the payment of a fee of 2s. in respect of each notification.

Medical Attendance on Members of the Military Forces and the Payment of Mileage.

At its previous meeting the Federal Council considered the payment of mileage or a travelling allowance to civilian practitioners who were called on to attend members of the military forces at a distance. The matter had been brought up for consideration by the New South Wales Branch which quoted a letter from the Deputy Director of Medical Services in New South Wales, stating that the fee for any distance in excess of two miles was 6d. a mile, but that special cases would be considered on their merits. The General Secretary reported that he had communicated with the Director-General of Medical Services and had suggested to him that payment should be made according to the schedule provided for the Emergency Medical Services. The Director-General had replied, stating that a recent amendment to Army Finance Regulations provided that civilian practitioners who used their own cars would be paid at the rate of from 5d. to 7d. per mile, depending on horse-power. The New South Wales, Western Australian and Victorian Branches had all suggested that a protest should be made against this decision, and that the Federal Council should press for the payment of the Emergency Medical Services rates. The Western Australian Branch laid stress on the time of the civilian practitioner that was taken up when he rendered the service. Dr. W. F. Simmons pointed out that services medical officers did work of this kind in government time and that the civilian practitioner did it in his own time. He therefore moved and Dr. N. M. Cuthbert seconded a motion to the effect that a letter of protest should be sent to the Minister for Army.

Emergency Medical Services: Deferred Pay and Conditions of Service.

At its previous meeting the Federal Council, at the instance of the Western Australian Branch, considered terms of service under the Emergency Medical Services. Special reference was made at that time to the question of deferred pay. The General Secretary, after referring to the

previous discussion of the Federal Council, read a report that he had received from Dr. W. F. Simmons regarding the procedure adopted in the management of practices formerly held by medical practitioners now in the services and at present carried on by the Emergency Medical Service. Dr. W. F. Simmons gave the Council some information regarding the supply of drugs, instruments and dressings to Emergency Medical Service practices. The General Secretary pointed out that the question of the legality of deferment of pay would not now arise, because of the altered conditions under which medical officers in the Emergency Medical Services were at present serving. There was therefore no necessity to obtain legal opinion on the matter. The information was noted.

Rationing.

Reference was made to the question of medical certification in regard to rationing and to the enormous number of certificates which the average medical practitioner was called upon to give in this regard. The matter had been before the Federal Council at its previous meeting. The General Secretary reported that the Prime Minister had asked government departments to reduce the number of certificates required as far as possible and not to require the production of a medical certificate in a new regulation until the Director-General of Health had been consulted.

The General Secretary reported that he had received a letter from the executive officer of the Food Rationing (Special Diets) Committee, asking for the cooperation of the medical profession in the rationing of butter and cream for diabetics and persons suffering from certain other diseases. The General Secretary had replied that this cooperation would be given, and it was noted that advertisements on the question had appeared in the newspapers and that a printed statement had been sent by the department to every medical practitioner.

A letter was received from the Victorian Branch, asking the Federal Council to take up with the authorities the question of meat rationing for diabetics. The General Secretary reported that he had communicated with a member of the Food Rationing (Special Diets) Committee of the National Health and Medical Research Council, and had been advised that a liberal allowance of meat would be made to persons suffering from diabetes.

Proposal for the Establishment of a System of Food Control.

The General Secretary read a copy of a letter which had been sent by the Queensland Branch to the Queensland Minister for Health and Home Affairs. In this letter it was stated that the Council of the Queensland Branch of the British Medical Association viewed the present food situation with alarm, especially in regard to young children. It urged upon the Queensland Minister the necessity for action. The matter had not been referred to a Federal authority, because all the machinery for the distribution of food was controlled by State agencies. The Queensland Branch Council pointed out, first of all, that certain foods were luxuries for most adults, but necessities for children. The most important of these were milk, eggs and citrus fruits. These were at present being sold as luxury foods, though at the same time and in the same district parents could not purchase them. The Queensland Branch Council suggested that as a remedy ration books should be issued to infants and nursing mothers, and that certain dealers in every district should be required to supply these goods on the production of these books. It was thought that this could well be organized through baby clinics and similar bodies, and it was pointed out that incidentally an increased attendance at baby health centres would result. The Queensland Branch Council remarked that the present decline in small shops and non-delivery had led to much hardship and in some cases to actual illness. This affected especially young mothers or the young prospective mother, whose hands were already over-full. It led to unavoidable neglect of children, and was believed to contribute to the already high mortality of young children from respiratory diseases. It was thought that plenty of men and vehicles for delivery were available in the cities and larger towns, at least amongst those discharged from the services as medically unfit. The Queensland Branch also urged that in all emergency service committees and boards there should be a representative of the medical services, in order to put the point of view of the large but inarticulate part of the population affected. The General Secretary reported that he had sent a copy of this letter to the Honourable W. J. Scully, Minister for Commerce and Agriculture. The Minister had replied that the views of the Association would be borne in mind when next the matter of food control came up for consideration.

Medical Certification.

At the last meeting of the Federal Council consideration was given to a manpower circular, which had been issued in Queensland, directing that medical certificates from civilian practitioners should be submitted to the Deputy Director of Medical Services when doubt was cast upon the validity of the certificate. It was at that time resolved that the Federal Council should protest to the Director-General of Manpower against the circular. The General Secretary read the memorandum of an interview that he had had with the Director-General of Manpower, who had informed him that the circular referred to had been sent out by the Deputy Director-General of Manpower in Queensland on his (the Director-General's) instructions. The memorandum was noted.

A letter was received from the Tasmanian Branch, requesting that the Federal Council should give consideration to the danger to the confidential relationship between doctor and patient involved in the growing demand for detailed diagnoses in medical certificates required by government departments and business firms. It was pointed out that in some cases the diagnosis might be highly confidential, and that medical certificates might pass through the hands of many members of an office staff. The Tasmanian Council thought that such certificates should state only the unfitness of the patient for work, and that no reason should be given. Unfortunately many departments and firms would not accept certificates without a diagnosis. After a general discussion it was agreed that the Tasmanian Branch should be reminded of the customary procedure, namely, for the doctor to hand the certificate to the patient, who could then do what he liked with it. The medical practitioner's responsibility ended when he handed the certificate to the patient.

Attendance on Naval Ratings in Public Hospitals.

Further consideration was given to the attendance on naval ratings in public hospitals by civilian practitioners. At the previous meeting of the Federal Council it was held that the navy should not expect free service from the members of the profession for attendance on its personnel, and it was resolved that the matter should be taken up with the Navy Board. The General Secretary reported that he had written to the Naval Board, but had not received a reply.

Protection of Practices Schemes in South Australia.

At the previous meeting of the Federal Council a letter was received from Professor J. B. Cleland and Dr. H. M. Birch regarding the payment of income tax upon contributions to the consultants and specialists' scheme for the protection of practices in South Australia. The Deputy Commissioner of Taxation in South Australia had ruled that contributions to this scheme by medical practitioners employed by public bodies were not allowable as income tax deductions. It was resolved at that meeting that the matter should be taken up with the Commissioner of Taxation. The General Secretary reported that he had written to the Commissioner of Taxation, and had inquired whether the interpretation was correct. The Commissioner had replied that both Professor Cleland and Dr. Birch were employees, and that the decision of the Deputy Commissioner of Taxation in South Australia was correct.

Shortage of Civilian Medical Practitioners.

The General Secretary reported that the Victorian Branch had written to the Federal Council about the shortage of civilian medical practitioners; it regarded the position with alarm. The Victorian Branch asked that representation should be made without delay to the Central Medical Coordination Committee, and that its attention should be drawn to the urgency of the matter. The Victorian Branch Council pointed out that several civilian practitioners had died and that a number of those who were at work were invalids and ought not to be working. Dr. N. M. Cuthbert said that there was only one solution that he could see, and that was that a pool of *locum tenentes* should always be available, and that this pool should be created even if a one-man town had to go without a doctor. No force of any kind could function properly without reserves, and the practising medical profession in Australia at present had no reserves. The pool would exist in order to afford relief to civilian doctors when they were ill or when they stood in need of a rest. Dr. H. C. Colville doubted whether this suggestion was practicable. There was an acute shortage, and sections of the population were not receiving sufficient medical care. The trouble was that some medical officers

would not come out of the army. This was a sphere in which the compulsory element was lacking. He thought that the situation would never be remedied until compulsion was used to have a man released from the services. The President said that it was a fact that the army would not release any man who did not wish to be released. It was decided on the motion of Dr. H. C. Colville, seconded by Dr. George Bell, that the matter should again be referred to the Central Medical Coordination Committee as a matter of urgency.

Shortage of Motor-Cars.

Correspondence was received from several of the Branches regarding the shortage of motor-cars. It was pointed out that medical practitioners had to have motor-cars in order to conduct their practices. The cars of quite a number of practitioners had outlived their usefulness, and new cars could not be obtained. It was resolved on the motion of Dr. H. C. Colville, seconded by Dr. George Bell, that a letter should be sent to the Minister for Supply, drawing his attention to the situation and asking that an effort should be made in the interests of the sick public to secure motor-cars that were necessary for medical practitioners.

The Supply of Brandy for Medicinal Purposes.

A letter was received from the Queensland Branch in regard to the supply of brandy for medicinal purposes. It was stated that it was legal for pharmacists to supply brandy required by medical practitioners for their patients, but that the pharmacists found it impossible to obtain any brandy.

The Directorship of Major Research Institutes in Australia.

Reference was made to some correspondence which had passed between the chairman of the Standing Committee of Services Medical Directors and the President regarding appointments to the directorships of major research institutes in Australia during the war. Special reference was made to the Walter and Eliza Hall Institute of Research in Pathology and Medicine and to the Institute of Medical and Veterinary Science at Adelaide. The General Secretary reported that he had written to the institutes in question, suggesting that the appointment to the directorships should be temporary and for the duration of the war only. The Secretary's action was approved.

Matters Deferred.

It was resolved that consideration of the Federal Emergency (Compensation) Fund, the public medical services and the principles of medical ethics should be deferred.

Date and Place of Next Meeting.

It was resolved on the motion of Dr. George Bell, seconded by Dr. W. F. Simmons, that the determination of the date and place of the next meeting should be left in the hands of the President.

Votes of Thanks.

A vote of thanks was accorded to the Victorian Branch Council for its hospitality during the meeting and for the use of its offices. Dr. George Bell also extended the thanks of the meeting to Sir Henry Newland for presiding.

Medical Societies.

THE MEDICAL DEFENCE SOCIETY OF QUEENSLAND.

THE annual meeting of the Medical Defence Society of Queensland was held on February 9, 1944.

ANNUAL REPORT.

The following annual report was adopted.

The Council has pleasure in presenting the following report of the Medical Defence Society of Queensland for the year ending December 31, 1943.

Membership.

The total membership of the society is 423. During the year 25 new members were elected and 5 were reinstated. Our losses have included: left the State, 3; deceased, 9; and 5 members who have not paid their subscription for 1943.

One hundred and one members are on service with His Majesty's Forces.

Obituary.

It is with deep regret that we record the deaths of the following members: Dr. A. B. Brockway, who was a foundation member and the first honorary secretary of the society, Dr. J. A. Cameron, Dr. Gullford Davidson, Dr. B. Gilmore Wilson, Dr. Reginald Williams, Dr. E. H. Beamer, Dr. A. W. Bayley.

Roll of Honour.

Dr. C. E. Thelander, who lost his life in the sinking of the hospital ship, *Centaur*, and Dr. J. H. Samuels, who was killed in action in the Middle East.

Office-Bearers and Councillors for 1943.

The following were reelected:

President: Dr. Alex. H. Marks.

Vice-President: Dr. S. F. McDonald.

Honorary Secretary: Dr. Neville G. Sutton.

Honorary Treasurer: Dr. L. P. Winterbotham.

Councillors: Dr. A. G. Anderson, Dr. Gavin H. Cameron, Dr. G. P. Dixon, Dr. E. R. Row, Dr. John Hardie, Dr. Kenneth Wilson, Dr. R. A. G. Malcolm.

The retiring members were Dr. S. F. McDonald, Dr. Neville G. Sutton and Dr. A. G. Anderson, all of whom were reelected.

Medico-Legal.

Only one new case was submitted to the society during the year, and the member was referred to the society's solicitors. This concerned a claim for damages for alleged negligence, and the writ was issued in Sydney where the patient now resides. It was agreed to pay the legal costs involved, provided that the society's solicitors act for the member, and that the action is brought in Queensland. The alleged negligence is stated to have occurred in Queensland in 1938. Nothing further has been heard in the matter to date.

There have been no developments in a case referred to in the last annual report.

A matter referred to the Council was the question of issuing a certificate to allow a patient to obtain brandy from a hotel, prior to opening time, where the patient was found by the police and a summons was served on him for being on licensed premises illegally. The doctor was asked to withdraw the certificate, which he did not consider would be honourable. The member was advised that if he issued a certificate in good faith, which was *ultra vires* so far as the licensing laws for hotels is concerned, he can cancel the certificate so that it cannot be used any longer. A doctor issues a certificate to state that a patient requires, say, brandy, but the onus is on the patient to obtain the spirit subject to the laws governing the avenue of supply. No doctor has any right to issue a certificate which in any way contravenes the laws of the country.

In accordance with a resolution passed at the last annual meeting of the society, a recommendation was sent to the Council of the Queensland Branch of the British Medical Association regarding the phraseology in the Model Lodge Agreement form wherein it is stated, "... the medical officer shall when required attend to members in cases of fractures", and suggesting that the word "shall" be altered to "may". The matter was referred to the Federal Council of the British Medical Association in Australia, the ruling being given that, in view of the fact that no difficulties have arisen in regard to the Common Form of Agreement in the various States in this respect, and after obtaining legal advice, it was decided that no alteration be made in the wording.

Indemnity Insurance.

During the year negotiations have continued with the London and Counties Medical Protection Society, who have agreed to accept a block of 100 members or more at a reduced rate of subscription of £2 5s. and individual members at £3 per annum sterling (that is, £2 16s. 6d. and £3 15s. respectively in Australian currency). This would be in addition to the local subscription of 10s. 6d. per annum payable to the Medical Defence Society of Queensland.

In this way it is hoped to provide members who enrol with a definite protection up to £1,000 in any one case, or the sum of £2,000 in any one year of overseas membership of the London and Counties Medical Protection Society. So far only 87 members have agreed to participate in this arrangement for extra protection. This means that at present we are not in a position to take advantage of the reduced rate of subscription offered for a block of one hundred.

Two circulars have been sent to members during the year explaining the position very fully.

Finance.

The balance sheet shows that the net surplus for the year amounted to £366 19s. 3d. The sum of £198 15s. was received from entrance fees and annual subscriptions, and a total of £226 6s. 11d. from investments, viz., Commonwealth loan and bank interest. The income for the year was £425 1s. 11d. General expenses amounted to £45 12s. 11d., and legal expenses were £12 9s. 9d.

The total assets of the society are £6,571 5s. 3d.

(Sgd.) ALEX. MARKS,
President.

The Royal Australasian College of Physicians.

SIXTH ANNUAL MEETING.

THE sixth annual meeting of The Royal Australasian College of Physicians will be held at Sydney on Friday and Saturday, April 21 and 22, 1944.

On Friday, April 21, 1944, the programme will include a council meeting in the morning at which the new office-bearers will be inducted and new members will be admitted, and a meeting of the general body of fellows and the annual general meeting in the afternoon. The Second G. E. Renzie Memorial Lecture will be delivered after the general meeting by the retiring President of the College, Sir Trent Champion de Crespigny, K.B., D.S.O., V.D., M.D., F.R.C.P. (Lond.), F.R.A.C.P. The lecture will be entitled "Torula Infection of the Central Nervous System".

The Second Annie B. Cunningham Lecture on Nutrition will be delivered on the evening of Friday, April 21, 1944, by Dr. C. G. McDonald, F.R.A.C.P., and the subject of his lecture will be "Diet and Disease". A scientific programme will be arranged for the morning of Saturday, April 22, 1944.

A detailed programme of the meeting will be published in these columns at a later date.

Correspondence.

THE WOMEN'S HOSPITAL, CROWN STREET, SYDNEY.

SIR: As a member of the Executive of the Crown Street Women's Hospital Golden Jubilee Appeal Committee, I would like to add a few observations of my own to the letter of the president and senior honorary obstetrician and gynaecologist.

A few weeks ago I had good reason to be thankful to the mobile blood transfusion service of the hospital, which turned out promptly at three o'clock in the morning to an obstetric case of mine. I may say that I was most impressed with the efficiency of the young doctor and nurse in their management of this rather desperate emergency. I feel all the more grateful to them now as my exsanguinated patient made an immediate and uninterrupted recovery.

Shortly after this experience, at my own request I was conducted over the hospital by Dr. A. J. Gibson and one of the vice-presidents. I found it hard to believe that such a modern blood transfusion team could have emanated from this antiquated and rambling place. The operating block alone would be considered a disgrace to any hospital in a large country town. Primitive make-shift contrivances, additions and alterations were everywhere in evidence, and the obvious over-crowding in all wards and balconies must surely be quite a problem for patients and nurses alike. I wondered if the politicians realized what a tremendous amount of highly specialized work is being carried out in this unsightly and depressing environment. Situated as it is

among the slums of Sydney, I suppose the set up should not be considered altogether incongruous.

As one excuse for this letter, I thought that others like myself, who have been glad of expert assistance from the hospital at some time or other, would be interested to hear what the interior of this famed institution really looks like.

Yours, etc.,

K. S. MACARTHUR BROWN.

Parramatta.

February 27, 1944.

PSYCHIATRIC CASUALTIES.

SIR: In the hope that a number of men on active service may be spared a lot of unnecessary suffering, I am writing these few lines. In the December 4, 1943, issue of your journal Major Sinclair has given an interesting exposition of psychiatric casualties in operational zones in New Guinea, but he has omitted to mention, which, perhaps, is the most potent factor in producing these conditions, infections, of which sinus infection plays a very dominant part. During the last war I drew attention to the part that infections played in what was then termed "shell shock". Langdon Brown many years ago pointed out that the sympathetic nervous system was the mechanism we employed to combat aggression not only against man and beast with all his weapons, but also against bacterial infections, and the same mechanism comes into play when either has to be dealt with. This train of symptoms can be seen in the out-patient department as well as behind the firing line. One can safely say that a very large number of men on active service have infected tonsils and a fair number have chronic sinus infection. A flare-up of either of these conditions *plus* the nerve strain of front-line warfare is more than the average man can stand, whereas either of them alone might be within his means to deal with. I would earnestly plead that this aspect of war neuroses be not overlooked and adequate treatment given.

Yours, etc.,

SYDNEY PERN, M.R.C.S., L.R.C.P.
(England).

Ballarat,

January 26, 1944.

OCULAR TORTICOLLIS.

SIR: I have lately noticed a tendency among some of my colleagues to vary the procedure of dealing with the over-acting inferior oblique at its origin on the orbital margin by attacking the tendon at or near its insertion into the globe. The late Bernard Chavasse also advocated this.

I have no knowledge of the practical effect of this as I have never done it, nor do I intend to. But I venture to suggest that to do so is to misunderstand the principle involved. In theory, dividing the tendon near the globe should abolish its action. Now one does not desire to abolish its action, but merely to lessen it. When the muscle is severed near its origin on the bone, and a small piece excised, I suggest that henceforth it will take its pull from the surrounding connective tissues to which it will become attached. It will not slide into space and become functionless. Its action will become restrained, which is the object aimed at. And in practice it works. The objection of a facial scar is largely illusory. If the incision is made in the soft skin just within the orbital margin, and not in the firmer skin on the malar eminence, in a month or so it will be invisible.

Yours, etc.,

E. TEMPLE SMITH.

Locarno,

141, Macquarie Street,
Sydney.

March 2, 1944.

STERILITY.

SIR: The universally recognized incidence of the male partner being at fault in sterility cases is 25% to 30%, and until the latter part of 1942 this had been the rate in cases I had investigated. During the last three months of that year and the first two months of 1943 there was a sudden increase of couples coming to me for investigation, and in most of these the husband had recently returned from the Middle East. In sixteen successive cases, the male was

definitely at fault in fourteen, and twelve of these were otherwise healthy members of the forces.

The sperm examinations performed by Dr. Spearman and Dr. Shipton showed very small counts and a preponderance of abnormal forms; very few showed the presence of pus cells. During the last twelve months about 50% of the cases showed the husband at fault, and the majority of these were soldiers on leave from New Guinea.

What is the cause of this sudden increase of male sterility? I can only presume that it is due to a faulty diet, a diet deficient in vitamin E. We know that the army diet was deficient in vitamin B, and that this was added to it. Vitamin B and vitamin E occur mostly together in nature, and where vitamin B is deficient, so also is vitamin E. Lack of vitamin E causes degeneration of the spermatogenic cells of the testicle, and once this has occurred no amount of vitamin E will restore their function.

If my presumption is correct, and I cannot see any other explanation, the post-war birth rate will be greatly affected, so I am writing you this letter to bring my experiences before other members of the profession to ascertain if they have had a similar experience in the great increase of the male sterility rate, and to the military authorities so that they may add vitamin E to the soldier's diet if it is found deficient.

Yours, etc.,

C. COGHLAN.

175, Macquarie Street,
Sydney,

February 24, 1944.

Post-Graduate Work.

MEDICAL JOURNALS AND TEXT-BOOKS FOR MEDICAL OFFICERS IN FORWARD AREAS.

THE NEW SOUTH WALES POST-GRADUATE COMMITTEE IN MEDICINE has been requested to assist in providing medical journals and text-books for medical officers serving in forward areas who have no access to such facilities which may be available to hospital units. The committee would be pleased to receive from any medical men and others any discarded medical journals or text-books which could be forwarded in this way.

Journals and text-books may be left at the office of the Post-Graduate Committee, 145, Macquarie Street, Sydney, where they will be collected by Colonel A. M. McIntosh, D.D.M.S., N.S.W. L. of C. Area, and sent to Brigadier Furnell in New Guinea, who will supervise their ultimate distribution.

Naval, Military and Air Force.

APPOINTMENTS.

THE undermentioned appointments have been promulgated in the *Commonwealth of Australia Gazette*, Number 39, of February 24, 1944.

ROYAL AUSTRALIAN AIR FORCE.

Citizen Air Force: Medical Branch.

Flight Lieutenant F. T. Bowden (252772) is transferred from the Administrative and Special Duties Branch with his present rank and seniority in that rank with effect from 31st January, 1944.

Reserve: Medical Branch.

William Thomas Lesslie, B.A., M.D., Ch.B. (267619), is appointed to a commission on probation with the rank of Flight Lieutenant with effect from 10th January, 1944.—(Ex. Min. No. 54—Approved 23rd February, 1944.)

DECORATIONS.

Surgeon Lieutenant R. M. Macintosh has been created a member of the Military Division of the Most Excellent Order of the British Empire for courage, endurance and devotion to duty.

Temporary Surgeon Lieutenant Frank Lionel Roden Smith has been mentioned in dispatches for outstanding skill and devotion to duty.

CASUALTIES.

ACCORDING to the casualty list received on March 6, 1944, Major M. H. Thomas, A.A.M.C., of Manly, New South Wales, has been placed on the "seriously ill" list.

Obituary.

KARL OWEN JONES.

We regret to announce the death of Dr. Karl Owen Jones, of Campbelltown, New South Wales, which occurred at Manly on February 27, 1944.

OLAF FRANCOIS DE LACY.

We regret to announce the death of Dr. Olaf Francois de Lacy, which occurred in February, 1944, at Tocumwal, New South Wales.

JAMES CHARLES MORTON.

We regret to announce the death of Dr. James Charles Morton, which occurred on February 27, 1944, at Hampton, Victoria.

Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association:

- Love, Colin James, M.B., B.S., 1943 (Univ. Sydney), 31 Coolong Road, Vaucluse.
Hall, George Vincent, M.B., 1939 (Univ. Sydney), 113th Australian General Hospital, Concord.

Medical Appointments.

Sir Raphael West Ciento has been appointed a member of the Senate of the University of Queensland.

Dr. Leonard Allan Windsor-McLean has been appointed a health officer at Brisbane for the purposes of *The Health Acts*, 1937 to 1943.

Dr. John Lewers Grove has been appointed to the Board of the Launceston Public Hospitals District, Tasmania.

Books Received.

"Sternal Puncture: A Method of Clinical and Cytological Investigation", by A. Piney, M.D., M.R.C.P., and J. L. Hamilton-Paterson, M.D., M.R.C.S., with a foreword by the Rt. Hon. Lord Horder, M.D., F.R.C.P. Second Edition; 1943. London: William Heinemann (Medical Books) Limited. 8½" x 5½", pp. 79, with many illustrations, most of which are coloured. Price: 15s. net.

"Ventilation and Heating: Lighting and Sealing", Medical Research Council, Industrial Health Research Board: Conditions for Industrial Health and Efficiency Pamphlet Number 1; 1943. London: His Majesty's Stationery Office. 8½" x 5½", pp. 20, with illustrations. Price: 3d. net.

"Endocrine Disorders in Childhood and Adolescence", by H. S. Le Marquand, M.D. (London), M.R.C.P. (London), and F. H. W. Tozer, M.D. (London), M.R.C.P. (London); 1943. London: Hodder and Stoughton Limited. 8½" x 5½", pp. 306, with illustrations. Price: 15s. net.

"An Introduction to Dermatology, with a Chapter on the Theory and Technique of X-Ray and Radium Therapy", by E. H. Molesworth, M.D., Ch.M. (Sydney), F.R.A.C.P., Dip. Rad. (Sydney), with a Foreword to the First Edition by Professor Josef Jadassohn; 1944. Sydney: Angus and Robertson, Limited. 8½" x 5½", pp. 592, with 162 illustrations in the text. Price: 37s. 6d.

"Dust Hazards in Australian Foundries", by A. A. Ross, B.Agr.Sc., and N. H. Shaw, B.Agr.Sc., Technical Report No. 1, Industrial Welfare Division, Department of Labour and National Service, Commonwealth of Australia; 1943. Melbourne: Department of Labour and National Service. 9½" x 6", pp. 48.

"V.D.", by A Doctor, A Psychologist, A Parson; 1943. Sydney: The Anglican Truth Society. 6" x 4½", pp. 18. Price: 6d.

Diary for the Month.

- MAR. 13.—Victorian Branch, B.M.A.: Hospital Subcommittee.
MAR. 13.—Victorian Branch, B.M.A.: Finance Subcommittee.
MAR. 14.—New South Wales Branch, B.M.A.: Medical Politics Committee.
MAR. 14.—New South Wales Branch, B.M.A.: Ethics Committee.
MAR. 14.—Tasmanian Branch, B.M.A.: Branch Meeting.
MAR. 14.—Victorian Branch, B.M.A.: Organization Subcommittee.
MAR. 15.—Western Australian Branch, B.M.A.: Branch Meeting.
MAR. 16.—Victorian Branch, B.M.A.: Executive Meeting.
MAR. 22.—Victorian Branch, B.M.A.: Council Meeting.
MAR. 24.—Queensland Branch, B.M.A.: Council Meeting.
MAR. 28.—New South Wales Branch, B.M.A.: Council Quarterly.
MAR. 30.—New South Wales Branch, B.M.A.: Annual Meeting.
MAR. 31.—Queensland Branch, B.M.A.: Branch Meeting.
APR. 4.—New South Wales Branch, B.M.A.: Council Meeting.
APR. 5.—Victorian Branch, B.M.A.: Branch Meeting.
APR. 5.—Western Australian Branch, B.M.A.: Council Meeting.
APR. 11.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
APR. 11.—New South Wales Branch, B.M.A.: Organization and Science Committee.
APR. 11.—Tasmanian Branch, B.M.A.: Branch Meeting.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phoenix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

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Members and subscribers are requested to notify the Manager, THE MEDICAL JOURNAL OF AUSTRALIA, Seamer Street, Giebe, New South Wales, without delay, of any irregularity in the delivery of this journal. The management cannot accept any responsibility or recognize any claim arising out of non-receipt of journals unless such a notification is received within one month.

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